



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
Massachusetts**

**Application for 2013
Annual Report for 2011**



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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Massachusetts hereby attests to all of the Assurances and Certifications required for this Application. Copies signed for this application are on file with the Massachusetts Department of Public Health and are available upon request to either the Title V Director or the Department's Chief Financial Officer.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

Extensive public input into the development of the MCH Block Grant Application this year has focused on the needs assessment process, which is described fully in our Five-Year Needs Assessment document attached to Part IIB. of this Application.

Drafts of the Needs Assessment findings, along with links to the previous Application, state Performance Measures, and Priority Needs, have been posted on the Department's website for review and comment. The final Application and Annual Report will be posted there as well, so that any additional input can be incorporated into the final Application, Annual Report, and Needs Assessment documents this fall, along with any revisions or suggestions from our federal review.

/2012/ Public input has been especially valued as we conducted a Needs Assessment and subsequent Updated State Plan for the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program funded through ACA. To inform the needs assessment, we held three public "listening sessions" with providers of and participants in home visiting programs to gather their insight, knowledge and lessons learned in the field of home visiting. We also sent a survey to stakeholders including program directors and administrators to gather information on their program goals, objectives, participant demographics, service delivery information, program gaps and areas of concern. Information from this survey was compiled and shared with stakeholders at the state and community levels. Finally, we held a community forum to bring together stakeholders from 17 communities identified in the needs assessment as high need to discuss community readiness to expand home visiting and enhance community and statewide early childhood systems of care. The breadth of the MIECHV needs assessment and public process addressed a wide range of elements relevant to the preparation of the Block Grant as well.

Although we keep the documents mentioned above on the state website, with links to the TVIS site at MCHB, virtually no comments or feedback are gathered through that mechanism. We are exploring a system that Connecticut has tried this year to provide bookmarks to the application and other documents to make it easier for persons to find text of interest to them.

Over 150 parents and family members of CSHCN including 38 Spanish and 5 Portuguese speaking parents have provided substantial consultation through various venues for the Family Support Plan/MCH. As expected, families for whom English is not their first language report more difficulties navigating the health care and insurance systems. Families reported issues similar to prior years. Medical home, family support, and constituency-building were identified as priorities. In FY 12, MDPH will continue focus on supporting families at the community level to better access health services and to broaden knowledge of medical home components. Materials and skill building will be available in Spanish.

Finally, the Bureau and senior staff took advantage of numerous opportunities throughout the year to listen to stakeholders and interested organizations about their concerns, priorities, and suggestions for improvements to the Title V program and related activities. Examples of specific input opportunities include bi-monthly meetings of the Early Intervention Interagency Coordinating Council, the Birth Defects Advisory Group, the Newborn Hearing Screening Advisory Group, and interagency Children's Behavioral Health Initiative. //2012//

//2013/ The Massachusetts Home Visiting Initiative (MHVI -- formerly MIECHV) funded through the ACA continues to engage actively with community partners and program participants to inform the implementation, evaluation, and continuous quality improvement. To effectively implement the program, MHVI established five implementation teams: Systems and Sustainability, Data and Evaluation, Evidence-based Home Visiting Models, Training, and Universal One Time Home Visiting. Each of these teams has identified ways to incorporate community voices and perspectives. In addition, MHVI is organizing a second forum for stakeholders from the 17 communities receiving MHVI funding to enhance, build and coordinate community coalitions, advisory boards, or councils working to build early childhood systems of care. Each community agency receiving the MHVI grant is encouraged to expand and/or strengthen their existing advisory board or council to enhance program delivery and strengthen early childhood systems of care. //2013//

//2013/Again this year, the Bureau and senior staff took advantage of numerous opportunities throughout the year to listen to stakeholders and interested organizations about their concerns, priorities, and suggestions for improvements to the Title V program and related activities. Examples of specific input opportunities include bi-monthly meetings of the Early Intervention Interagency Coordinating Council, a federally mandated body, to advise and guide the MDPH in matters related to Early Intervention specifically and Early Childhood and Children and Youth with Special Health Needs more generally, the Birth Defects Advisory Group, the Newborn Hearing Screening Advisory Group, and interagency Children's Behavioral Health Initiative where the Title V Director has participated consistently with the Executive Steering Team and the more programmatically focused implementation team. Additionally, opportunities for guidance on operation of the Title V program have occurred through active participation with the Young Children's Sub-Committee of the Children's Readiness Cabinet, Race to the Top- Early Learning Challenge and Evidenced Based Home Visiting higher level planning and implementation activities.//2013//

//2013/ As part of its Needs Assessment prior to issuing a new RFR for Family Planning Services, the Family Planning Program sought significant public input through two surveys, one of reproductive health stakeholders and another of young people from across Massachusetts. The results have helped shape the RFR, plans for future services (See Section II.C Needs Assessment Summary, NPM # 8, SPM #1, and Priority # 5 for additional information), and the broader shape of MCH programming in an era of health care reform. //2013//

Attached to this section is an updated list of advisory committees that help inform the Title V

program. Each advisory group discusses aspects of the Title V application and needs assessment that pertain to it. Input over the course of the year helps keep Title V up to date.

An attachment is included in this section. IE - Public Input

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The people served by the programs of Massachusetts Maternal and Child Health grant have experienced great changes in the last several years. To respond effectively to these changes, starting in mid-2009, the Massachusetts Department of Public Health (MDPH) conducted a systematic review of changes and needs in the state led by the Title V Director, Ron Benham. A MDPH-wide Steering Group comprised of senior leaders from throughout the Department oversaw the project, which included extensive data collection and analysis and engagement with internal and external stakeholders using surveys, key informant interviews, focus groups, and public hearings on the draft priorities. An additional comprehensive multi-layered needs assessment (using 29 indicators in eight domains) was conducted in FY10 for our application for ACA MIECHV funding.

Massachusetts Title V has used the perspectives of the Life Course Model and Social Determinants of Health to ensure relevance to the current MCH populations. Our 2010 Priority Needs (which are listed on Form 14) were selected based on changes in the state over the previous five years and on opportunities looking forward. Expanding the capacity of programs and services to improve the health outcomes of the MCH population is an ongoing effort as Massachusetts develops action planning to improve these priority areas.

In this 2013 update, we summarize several subsequent needs assessments and analyses of new data that are being incorporated into our programmatic and policy agendas.

In addition to the information presented below, updated birth data and other statistics are presented throughout this Application with relevant Performance Measures, Health Systems Capacity Indicators, and Health Status Indicators. [NOTE: The release of mortality data for CY2009 and CY2010 has been delayed and therefore we do not have updates related to a number of measures and indicators.]

See the following section (Section III.A. -- State Overview) for updated details on Massachusetts demographics from the 2010 Census, which were not available at the time of our previous Application.

We continue to monitor trends in health care access and costs and the effects of the economy on our target populations. Updates on both those topics are also presented in the next section.

In 2010 (the most recent year for which data are available), birth data improved in a number of areas. The teen birth rate improved and is well below the national rates. The percentage of mothers who received adequate prenatal care increased again, driven by an increase in the percent of women initiating care in the first trimester. The IMR among Black mothers reached a record low in 2009 (the most recent data available), driven by a significant decline of 42% in the neonatal mortality rate and the Black to White IMR ratio narrowed to 1.9, down from 3.6 in 1990. All of these rates, along with LBW rates and the percentage of VLBW infants born in Level III hospitals are already better than their Healthy People 2020 targets.

The Massachusetts Title V program has historically been a leader in the development of a statewide system of services that reflect the principles of comprehensive, community-based, family-centered care for CYSHCN. An extensive review of where we stand on the MCHB-defined four constructs by which to assess the service system for CYSHCN and state involvement with it

was included in our Five-Year Needs Assessment. A stand-alone version of the constructs section, with annual updates, is included as an attachment to this section, as it is each year.

The number of children diagnosed with autism spectrum disorders (ASD) has grown significantly in the past decade and the costs of providing appropriate intensive behavioral services for children with ASD have consumed an increasing percentage of the Early Intervention budget. While the funding to support EI services in MA is quite diversified and includes significant support from private and public health insurers, the cost of these intensive behavioral services have been borne exclusively by MDPH. In FY12, collaborative efforts to diversify funding streams and to ensure appropriate access to evidenced-based interventions to all young children with ASD, based on these cost data have begun to pay off. See further discussion in Part IV, Section E (Agency Coordination) on progress with both MassHealth (the MA Medicaid program) and private insurers.

A wide-ranging family planning services needs assessment was conducted in FY12 prior to the Family Planning Program's competitive contract procurement for FY13. Data from BRFSS, YRBS, PRAMS, STD surveillance and other MDPH internal data sources were used to create a data-based rationale for redesigning the program to more effectively fill post-health reform service gaps. Among the data gathering tools were two surveys, one of reproductive health stakeholders and another of young people from across Massachusetts. Among the key findings from the surveys:

- People prefer to seek reproductive health services at their primary place of health care or in locations where they are receiving other services (e.g., school, youth-serving agencies).
- Young people would benefit most from improved access to quality reproductive health services.
- Providers expressed a desire for more flexible funding to conduct broader outreach activities and clinical activities in non-traditional settings.
- Barriers to care included the cost of medical services and contraceptives. Young people also overwhelmingly cited concerns about confidentiality and embarrassment or shame as primary reasons for not seeking sexual and reproductive health care.
- Over a third of young women requested services that would help them cope with violence, substance use, and nutrition.
- Stakeholders reported negative community attitudes and perceptions towards sexual and reproductive health services as a major issue.
- Stakeholders also requested support for collaboration with other community resources, school in particular, and for training, information distribution, educational materials development, and outreach campaigns.

In December 2011, Massachusetts was one of only 9 states to receive a "Race to the Top -- Early Learning Challenge Grant" (RTT-ELCG). Massachusetts' successful application was the result of collaboration across state agencies, with significant MDPH involvement, and with community leaders to develop a comprehensive, aggressive plan for a well-coordinated system of education and care for young children.

In May 2012, to advance strong partnerships across these multiple domains of childcare, health, housing, education, child welfare, mental health, and economic development, the Commissioner for EEC, with planning support provided by MDPH staff, hosted a one day retreat entitled "Fulfilling the Promise: Building Strong Inter-Agency Partnerships for the Success of Young Children." Substantive source materials including a summary of the grant, research on brain and child development, effective education and care system building and collaboration were provided to retreat participants. Identified strengths and assets that can be marshaled going forward in support of grant implementation fell into the following themes: data sharing on families and children with multiple risk factors, linked service delivery / response, and shared professional development.

A time-limited Critical Congenital Heart Disease (CCHD) Screening Advisory Work Group was

created this year to advise the department on the recommendation to add pulse oximetry screening for the detection of CCHD to the newborn uniform screening panel. It is being guided by analyses of CCHDs in the state, a survey of all MA maternity hospitals, and assessment of MA pediatric cardiologists.

Analysis of CCHDs in MA over the four-year period 2005 -- 2008 (from the Birth Defects Monitoring Program surveillance data) found that 88 (14%) of the 637 CCHD cases were "missed," or diagnosed post-natally after discharge home. The proportion of cases diagnosed prenatally increased by about 28% while cases diagnosed after discharge home fell by about 44%. A higher proportion of "missed" cases were observed in Level 1 and Level 2 hospitals, compared to Level 3 facilities (34% / 25% and 7% respectively). Of the 88 "missed" cases, 82 (93%) were delivered in one of 35 maternity hospitals representing all three levels of care; 6 cases were delivered at home; and one case was delivered at a birth center.

The hospital survey asked about the use of routine pulse oximetry screening and the capacity to care for and/or refer infants picked up in the screening. Forty-three of 47 maternity hospitals responded (91%). Of these, 25% are doing the screening (8) or planning to implement in June or July, 2012 (3), higher percentages than we had expected.

To gain a better understanding of the relationship between oral health care in pregnancy and maternal health and pregnancy outcomes in MA, MA PRAMS conducted a survey of physicians and dentists to assess knowledge and practices/treatments during pregnancy, and to describe referral patterns and barriers to care among pregnant women and providers. Findings were presented at four MA medical/dental/public health schools: Tufts, Boston University, UMass, and Harvard. The presentation focused on the statistics of oral health during pregnancy, the research behind perinatal oral health care and pregnancy outcomes, the imperative to improve the rates of screening among pregnant women, and the need for referrals between physicians and providers for oral health services delivered during pregnancy. The presentations were well received by both students and faculty and have helped build momentum for our SPM #04.

An attachment is included in this section. IIC - Needs Assessment Summary

III. State Overview

A. Overview

Massachusetts has long been at the forefront of public health. The State's population overall has high levels of income and education built upon a diversified economic base. These advantages have translated into a history of good availability and access to health services including a history of strong support for funding of health and social service programs. "During the 1700's, the smallpox inoculation was pioneered, the first pure food legislation was enacted and the first public clinics were opened." More recently, the state has served as a model for the nation by instituting comprehensive health care reform, significantly reducing the ranks of the uninsured and requiring all residents to have health insurance.

According to Milton Kotelchuck, Chair Emeritus and Professor at the Boston University School of Public Health, maternal and child health status in Massachusetts is good, "especially compared with to U.S. national rates." However, there remains room for improvement. Infant mortality rates have not improved since 2000 and low birth weight and prematurity rates have deteriorated in the past decade. Because of these and other factors, the need for special health and educational services, especially early intervention, has increased.

A significant trend in Massachusetts, as well as in many other parts of the country, is that births have become more diverse in terms of maternal race, ethnicity and age. At the same time, disparities in maternal and child health outcomes, according to Kotelchuck, and many others, "remain glaring." Many social determinants of health, including income, education, ethnicity and related, well-known factors have contributed to these disparities.

Title V Program Role

The Massachusetts Title V agency, the Bureau of Family Health and Nutrition (BFHN), reports directly to the Commissioner of Public Health, who reports to the Secretary, Executive Office of Health and Human Services (EOHHS). This structure provides Title V program with tremendous capacity to promote comprehensive systems of service, to coordinate initiatives, and to work collaboratively across the full range of relationships necessary for a comprehensive approach to Title V goals. The direct relation of the Massachusetts Title V program to the Department of Public Health means that the priorities and initiatives of both are entirely in sync and furthered by many formal and informal relationships.

The philosophy of the Massachusetts Title V program is that in order to fully address the health needs of mothers and children, systems, programs and services need to consider the health of the entire family, including the community, across the lifespan. In the Bureau of Family Health and Nutrition, all systems and programs begin with this philosophical approach -- addressing the needs of women, children and youth, including those with special health needs, within the context of the family. The state's philosophy simply stated is: "Healthy families lead to healthy children." More detail about the Title V program's capacity is provided in Section III. B. below.

Principal Characteristics

Massachusetts is the 15th largest state by population, based on 2008 estimates. In recent years, international migration into the state and births by foreign-born mothers have nearly offset the migration out of the state. The estimated population of Massachusetts grew by 2.3% between 2000 and 2008. The Commonwealth's 6,497,967 residents included the following: 15.9% are females aged 0-24 years; 16.2% are males aged 0-24 years; and 13.8% are women aged 25-44 years

The racial and ethnic make-up of Massachusetts has changed dramatically since the mid-twentieth century. In 1950, one out of 50 people was non-White; today, one in five is non-White. According to 2008 Census estimates, racial and ethnic minorities constituted 21% of the Massachusetts population (non-Hispanic Blacks 5.9%, Hispanics 8.6%, non-Hispanic Asians

4.9%, and two or more races 1.2%). This is a change of 4% since 2000 with a nearly 2% overall increase in the portion of Hispanics. In 2000, minorities constituted 17% of the population (Non-Hispanic Blacks 5.5%, Hispanics 6.8%, Asians 3.8%, and two or more races 0.9%).

By 2010, Massachusetts' population is projected to increase moderately to 6,649,441 with minority populations continuing to account for a large portion of population growth. In several Massachusetts communities, including Boston, minority groups now constitute the majority of the population.

Massachusetts continues to rank eighth in the U.S. in its population of foreign-born persons. The percent of foreign-born residents increased from 12.2% to 14.2% from 2000 to 2007. According to a 2007 report from the Pew Hispanic Center, among foreign-born persons in Massachusetts:

- 35% were from Latin America
- 27% were from Asia
- 27% were from Europe
- 7% were from Africa
- 4% were from North America.

Estimates of the number of immigrants and refugees, especially unauthorized immigrants, vary due to the inherent difficulty in counting changing populations whose language is not English. These individuals who experience cultural isolation are often reluctant to talk to outsiders, especially those who have questions about immigration status. A PEW study estimated the unauthorized immigrant population in the Commonwealth at 190,000, ranking the state as 14th in unauthorized immigrants, directly behind Maryland, Colorado, and Nevada.

Twenty percent of Massachusetts residents spoke a language other than English at home based on the 2007 census survey. Among those aged 5 years and older, 34% spoke Spanish at home, which represents the largest second language group. Among all those that speak a language besides English at home, 43% report speaking English 'less than very well'. Forty-five percent of Spanish native speakers and 50% of Asian and Pacific Island native speakers are "less than well" fluent in English.

Racial and ethnic differences often correlate with economic and health differences. Minority populations in Massachusetts in many cases have a lower socioeconomic status and have less access to services, including opportunities for exercise and access to healthy foods, in addition to preventive health services. Thirty-nine percent of those living below 100% FPL in Massachusetts are minorities, nearly twice as many as in the population as a whole. Forty-one percent of Hispanics and 30% of blacks live under 100% FPL in Massachusetts.

The high cost of living in the state challenges lower income and minority populations. Massachusetts has a lower portion of the population living under 200% of the FPL compared with the nation (31% versus 36%), but housing and food costs are also higher than in most of the country, putting economic pressure on many families. For example, a worker earning minimum wage (\$6.75) would have to work 134 hours a week to afford a two-bedroom apartment in Boston. The challenge for lower income individuals to maintain living standards in the state translates into decreased ability to move out of their current socio-economic class.

/2013/ Updated data are now available from the 2010 Census. Massachusetts is the 14th largest state by population; with an average of 840 people per square mile it is the 3rd most densely populated. The estimated population of Massachusetts grew by 3.1% between 2000 and 2010. The Commonwealth's 6,547,629 residents included the following: 15.8% females aged 0-24 years; 16.3% males aged 0-24 years; and 13.5% women aged 25-44 years.

According to the 2010 Census estimates, racial and ethnic minorities constituted 19.6% of the Massachusetts population (non-Hispanic Blacks 6.6%, Hispanics 9.6%, non-Hispanic

Asians 5.3%, and two or more races 2.6%. This is a change of 4% since 2000 with a nearly 2% overall increase in the portion of Hispanics. In 2000, minorities constituted 17% of the population (Non-Hispanic Blacks 5.5%, Hispanics 6.8%, Asians 3.8%, and two or more races 0.9%).

Massachusetts now ranks fourth in the U.S. in the percent of its population being foreign-born persons. According to the 2010 American Community Survey (ACS). The percent of foreign-born residents increased from 12.2% to 14.5% from 2000 to 2010. Of these foreign-born persons:

- **35.2% were from Latin America**
- **28.2% were from Asia**
- **25% were from Europe**
- **7.8% were from Africa**
- **3.4% were from North America**
- **0.3% were from Oceania. //2013//**

Unique Challenges, Current and Emerging Issues

The people served by the programs of the Massachusetts Federal-State MCH Partnership have experienced great changes in the last five years. We have categorized these changes into seven domains that emerged during our comprehensive needs assessment for 2010. The full needs assessment document (which is an Attachment to Section II, Part B.) presents considerably more detail about each topic.

1. Massachusetts Health Care Reform and Delivery of Services

In 2007, the Commonwealth embarked upon a substantial overhaul of its health care system, to reduce the number of uninsured residents, estimated at about 8.5% of the state's population aged 65 years and under in 1998. The legislature implemented a health insurance mandate with tax penalties and created the Commonwealth Health Insurance Connector Authority to link citizens with new and existing health plans that have varying levels of state subsidies, depending on members' income levels. By 2009, the Commonwealth decreased the proportion of the uninsured population to 3% and the rate continues to decline. Among children aged 18 years and under, only 1.2% are uninsured. Over 400,000 Massachusetts residents are newly insured, with 150,000 having joined the newly created Commonwealth Care plans.

While health insurance coverage is improving, a new bottleneck has emerged in the health system: access to primary care. Increasingly, too many people wait longer than six months for a physician appointment. In certain regions of the state, the number of primary care providers (PCPs) is insufficient to care for the population adequately, and many PCPs are not accepting new patients. There are also substantial regional disparities in access to specialty care (e.g., Ob/GYN in western Massachusetts) and widespread problems with access to culturally competent care, especially for non-English speakers.

Hospitals and Community Health Centers have a similar distribution to physicians and other providers across the state with high concentrations in the Boston area and limited access in rural regions. For populations that need coverage best performed outside of acute care facilities or private physician offices, the state relies on a strong network of Community Health Centers. The Centers provide preventive care, health screening, interventions and treatment, and co-site many programs supporting the MCH population such as co-located WIC local programs. As Massachusetts does not have a county- or city-based health services system, Community Health Centers (CHCs), along with a few remaining hospital outpatient departments, serve as the state's key safety net providers. Low-income uninsured and underinsured, high-risk Medicaid recipients and other individuals facing barriers are able to access health care through a statewide network of 52 CHCs that serve nearly 800,000 state residents through 285 sites. Ninety percent of Community Health Center patients have incomes below 200%FPL, with 67% belonging to a racial or ethnic minority group.

To summarize from the reviews of insurance, providers, and MCH program services, the priority state concerns are:

Access to care: In many rural and poor urban areas of the state, the number of specialty providers is insufficient to care for the population adequately, and many PCPs are not accepting new patients. For those not in a professional shortage area, the time to get an appointment with a primary care physician typically is long. The demand for services has increased without an increase in capacity following Health Reform. The availability of care is less for CYSHCN who have complex medical needs in addition to behavioral issues that may require special training. Some of the disparities in the distribution of physicians and other health professionals are the result of a critical imbalance in the ability of CHCs and other safety net providers within these underserved areas to recruit and retain physicians. These providers have difficulty in matching competitive salaries and benefits in this marketplace, particularly with those offered by hospitals and affiliated group practices.

Affordability of care: Despite Health Care Reform, high premiums and deductibles, in addition to co-pays, place a cost burden on low and middle income families.

Cultural/Linguistic appropriateness of services: Health provider agencies must ensure that their staff are well trained in medicine and also in the culture and language of the local population in need of services.

//2012/We are also concerned about the increase in the number of larger employers self-insuring, thus legally removing themselves from the requirement to honor state-mandated coverage of certain conditions. For example, significant payment responsibility falls to state appropriations within the Early Intervention Program due to some larger employers not covering the state-mandated early intervention benefit, with the MDPH being payor of last resort.

The continued increase in the number of infants and toddlers with a diagnosis in the Autism Spectrum presents an on-going significant fiscal challenge. Despite the passage of a mandated benefit for private insurance coverage of Applied Behavioral Analysis (ABA) and other treatment services through an Act Relative to Insurance Coverage for Autism (ARICA) that became effective 1/1/2011, the Early Intervention Program has not seen any financial benefit from the legislation. This is apparently due to somewhat unique dual coverage under Part C of I.D.E.A. and ARICA. Families staying within the Early Intervention Program do not have co-pays or deductibles and have therefore not moved to private insurance plan networks where such payments exist.//2012//

//2013/ Now that the individual mandate of the Affordable Care Act has been deemed constitutional and only the penalty portion of the Medicaid expansion provisions has been struck down, the challenges for Massachusetts remain the adjustments in our health care reform system to meet all of the federal requirements by 2014 (which while numerous should not be difficult) and the on-going battle against rising health care costs. On August 6, 2012, the Governor signed Chapter 224, "An Act Improving The Quality Of Health Care And Reducing Costs Through Increased Transparency, Efficiency And Innovation" that establishes landmark measures to lower costs and make quality, affordable care a reality for all Massachusetts residents.

The new law, which represents a compromise among versions of legislation filed by the Governor, the House, and the Senate, sets a first-in-the-nation target for controlling the growth of health care costs. The annual increase in total health care spending will be held to the rate of growth of the state's Gross State Product (GSP) for the first five years, through 2017, and then even lower for the next five years, to half a percentage point below the economy's growth rate, and then back to GSP. It is predicted to result in nearly \$200 billion in health care cost savings over the next 15 years.

In order to control costs and improve quality of care, the law requires government agencies such as MassHealth, the Group Insurance Commission (GIC) and the Connector to use global and other alternative payments to achieve savings for taxpayers. It also

encourages alternative delivery systems across health care fields to deliver additional savings for patients, business owners and working families.

To monitor and address the market power and price disparities that can lead to higher costs, the law allows a Health Policy Commission to conduct a cost and market impact review of any provider organization to ensure that they can justify price variations. The law identifies triggers for when a provider or provider organization will be referred to the attorney general for investigation. An independent Center for Health Information and Analysis will conduct data collection and reporting functions.

In a major leap forward for prevention across the lifespan, the law creates a Wellness Fund of \$60 million administered by the MDPH for competitive grants to community-based organizations, health care providers and regional planning organizations. \$15 million will be deposited in the Wellness Fund Trust each year for 4 years.

A more extensive summary of the provisions of the Act is provided as an attachment to this section.

The success of the Act will be critical for the Commonwealth. While the Massachusetts health care reform model has been enormously successfully in achieving almost universal health insurance coverage and it has not had any impact on employment or "crowding out" of employer-sponsored coverage (as some had predicted), it has not addressed the continuing escalation in health care costs. According to surveys conducted in 2010 by the Urban Institute, "Despite these significant achievements [including better access to primary care; specialist care; medical tests, treatment, and follow-up care; preventive care screenings, along with reductions in emergency department use and in inpatient hospital stays], Massachusetts continues to struggle with escalating health care costs, reflecting the decision to defer addressing costs in the 2006 legislation so as not to hold up the expansion in coverage. Consequently, the affordability of health care and financial problems related to high health care costs are burdens for many families in the state. In the absence of any intervention, the burden of high health care costs will worsen, as health care spending per capita in Massachusetts, already the highest in the country, is projected to nearly double between 2010 and 2020."

Some promising findings were just released from a major experiment with payment reform. Health spending for patients treated through Blue Cross Blue Shield of Massachusetts' pioneering global-payment program grew more slowly in 2010 than for patients whose physicians were paid the traditional way. At the same time, the 4,800 doctors in the program scored higher on measures of quality of care, compared to the control group, doctors with the alternative contract improved care for chronically ill adults and preventive care for both adults and children more quickly. Doctors with the alternative contract spent 3.3 percent less in 2010 than doctors not in the program, an average savings of about \$107 per patient. These savings not only rose in 2010 from more modest ones in 2009, but some doctors groups spent as much as 10 percent less than colleagues paid under the traditional fee-for-service system.//2013//

2. Impact of private sector economic conditions & projections

The second half of 2007 saw the start of a serious recession as the financial service sector declined across the nation. Throughout 2008 and 2009, the financial crisis had a substantial negative impact on corporate investment levels. In particular, unemployment rates reached historic highs in the US. Similarly, Massachusetts saw its own unemployment rate rise to over 9% by late 2009. State revenue is down 10.9% from 2008.

The severe recession has changed short-term behaviors and reduced long-term projections for the overall economy and subsequent state funds for public health. While it is too early to anticipate the long-term impact of the recession, the overall mood has become more conservative for both consumers and businesses. The state is experiencing higher demand for public health services even as state revenues to fund those services have fallen. State funding are likely to continue their decline or at best remain static for the foreseeable future.

/2013/ Slowly, the state economy is improving, with tax revenues up and unemployment down. At 6% in May 2012, our unemployment rate is significantly lower than the national average of 8.2%. However, housing remains a major problem, with foreclosure rates still high, median housing prices generally depressed, and housing sales and new construction starts not recovered. State budgets have stabilized, although public health has lost significant state funding over the last several years. Transportation systems debt, aging infrastructure needs (roads, bridges, etc.), municipal aid, and education continue to be challenges as increased taxes of any type are off the table as a solution while the recovery is still so shaky and many families are still suffering economic hardship and uncertainty about their economic futures. Job creation and re-hiring continue to be sluggish and lower than expected. Turmoil in Europe and uncertainty surrounding looming federal budget cuts present the greatest threat to state finances. Around 40 percent of the state's exports go to the European Union, so the state is more dependent on the international economy, especially the European economy, than other states generally.

The continuing sluggish economy and housing crisis have led to a marked rise in the number of homeless families seeking Emergency Assistance (EA) and being placed in shelters. As of June 2011, there were over 3,600 families with children seeking EA, with 1,498 of these being sheltered in motels. In 2011, over 3,000 families avoided homelessness by receiving short-term flexible funds. Over 7,000 families received emergency shelter, not including families not counted because they are doubled up, living in cars or living in unsafe conditions. According to the Massachusetts Coalition for the Homeless, the average age of a person experiencing homelessness in Massachusetts is eight years old, and on any given night, the 3,000 individual shelter beds are full. Between 2005 and 2010, the number of families receiving EA increased by 230%, and this trend has continued in 2012. //2013//

3. Demographics & Geography

Residents live in a wide mix of urban, suburban and rural areas. The eastern part of the state, excluding Cape Cod and the Islands, is relatively dense and urbanized compared to the west, which is mostly rural. According to 2008 census estimates, nearly 63% of the Massachusetts population lives within the group of eastern counties immediately surrounding and including Boston.

While the Western region looks comparably well covered by the medical community in terms of physicians, nurses, and hospitals per capita, the geographic distances covered and natural barriers between communities result in limited access to services. Rural and small town culture, a lack of resources such as transportation, and family and work-life needs are such that it is difficult for many rural residents to travel to cities to receive services on a regular basis. For instance, many communities in the Berkshires must cross a mountain range to visit the nearest secondary or tertiary care center or community health center. Similar to the Western region, the islands of Nantucket and Martha's Vineyard have populations too small to support major medical facilities and the year round community often has restricted access to mainland services in winter due to weather conditions and reduced ferry service.

4. Health & Wellness Trends

Massachusetts residents overall enjoy better health care and health outcomes than US residents on average. For instance, in terms of infant death rate, breast feeding initiation, teen pregnancies, and birth weights, Massachusetts ranks high against other states.

Yet we also have substantial racial, ethnic, and geographic health disparities, and we fall short of national averages in several critical areas. Infant mortality rates have ceased improving since 2000. Low birth weight and prematurity rates have steadily worsened for the past decade, increasing the need for more special health and educational services. Massachusetts has also experienced increases in gestational diabetes mellitus (GDM) and cesarean deliveries.

The following are some highlights in areas critical for the long-term well-being of Massachusetts residents:

Obesity

- All age groups have experienced an increasing prevalence of overweight and obesity. More than half (57%) of Massachusetts adults are obese or overweight (53% of women). Among children aged 2-17 years, 30% are obese or overweight. The proportion of births to mothers diagnosed with GDM increased by 49% between 2000 and 2007.

Infant and Children's Health

- Fetal deaths continue to account for more than half of the state's feto-infant mortality rate. Rates are highest for Hispanics and Black Non-Hispanics
- 10.3% of Massachusetts children have current asthma
- 50.9% of them had activity limitations due to asthma in the past year
- 65% of these children reported that their asthma was not well or very poorly controlled
- Children aged 0-3 years have experienced increasing speech delays. The Early Intervention (EI) Program served 10% more children in 2008 compared with 2005. EI expenditures are up to \$97M in 2008 vs. \$80M in 2005
- There has been a nearly 40% increase in the number of autistic children in EI in Massachusetts from 2005 to 2008

Violence and Injury

- Injury is the leading cause of death among Massachusetts residents aged 1-44 years. Most injury deaths in Massachusetts are unintentional (75%), followed by suicide (15%), homicide (6%), and those of undetermined intent, other, or adverse effects (4%). Unintentional injuries resulting in death were predominantly due to auto accidents (#1 cause of death among youth aged 15-24 years accounting for 37% of deaths).
- Among non-fatal unintentional injuries, falls were the leading cause of injury for all age groups under 14 years.
- Black males aged 15-24 years were 30 times more likely than White males to die from homicide. For Black non-Hispanic residents age 0-19 years, injury deaths from firearms were more than twice as high as motor vehicle deaths.
- Females (15%) report having experienced sexual violence at twice the rate of men (7%). Women with a disability (25%) were even more likely to have experienced sexual violence compared with women without disabilities (13%).
- Violence is prevalent among youth and especially youth with special health care needs. More than 1 in 4 high school (HS) students have been involved in a physical fight and 15% of youth in each grade report bullying. Fifteen percent of high school females have been physically hurt by a date and 19% have had sexual contact against their will.

Mental Health

- Massachusetts ranks 22nd nationally in reported poor mental health days. In 2008, 7% of Massachusetts adults reported 15+ days of feeling sad, blue, or depressed in the past month. Among Massachusetts youth aged 12-17 years, 9% suffered an episode of major depression in the past year.
- Suicide is the third leading cause of death among youth aged 11-18 years. Among high school students in Massachusetts during 2007, 24% reported feeling sad or hopeless enough to halt usual activity; just over ten percent report a suicide plan. From 1999 to 2005, 3,018 suicide attempts in the state of Massachusetts resulted in death.
- Postpartum depression affects women across different backgrounds, with less than half seeking help. Ten percent of women surveyed by PRAMS reported they often or always experienced little interest in activities postpartum. Other, non-Hispanic women (17.9%), those under the age of 20 (13.5%), those with some college education (16.2%), those living at or below poverty level (16.8%), and non-US born mothers (14.9%) were most likely to report loss of pleasure or interest in activities. Further, among women indicating they felt depressed often or

always, about 40% reported they sought help for depression.

Infectious Disease

- Rates of Chlamydia have increased since 2000. Among youth aged 15-19 years, the overall incidence of Chlamydia is 1080 per 100,000. However, the rate is disproportionately high in Boston and Western Massachusetts (2,890 and 1,641 respectively) compared to other regions.
- While the rate of diagnosis of new HIV/AIDS cases is declining, the prevalence of HIV/AIDS increased 26.5% from 2000 to 2006, in part due to more effective treatments. New cases disproportionately affected Blacks and Hispanics and were concentrated in the city of Boston.

Tobacco, Alcohol, and Drugs

- The number of women who reported smoking during pregnancy declined 60% (19.3% in 1990, 7.5% in 2007)
- In 2007, 63.1% of Massachusetts women aged 18-44 years reported any use of alcohol (vs. 50.3% nationally) and 19.5% of those reported binge drinking (vs. 14% nationally). In 2007, 11.5% of women reported alcohol use in the last 3 months of pregnancy
- A substantial percentage of youth engage in high-risk behaviors:
 - o Twenty-eight percent of high school students reported binge drinking in the previous 30 days.
 - o Nineteen percent of high school seniors have had four or more sex partners and more than one-third of sexually active high school students did not use a condom at last sex.
 - o One in four high school students reported having ridden in a car in the past 30 days with someone who had been drinking.

/2013/ The recently released findings from the 2011 Massachusetts Youth Risk Behavior Survey (YRBS) and the Massachusetts Youth Survey (given in a coordinated manner and reported jointly) provide some updated information about children and youth in Massachusetts.

The percentage of high school students who reported being bullied at school has significantly declined from 23% in 2003 to 18% in 2011. For the first time, the report also included data on rates of cyber-bullying. In 2011, 14% of middle school students and 16% of high school students reported being victims of cyber-bullying.

Rates of alcohol use are declining among both high school and middle school aged youth in Massachusetts, according to the report. Lifetime alcohol use among high school students has shown a significant decline since 2003, from 75% to 68%. Fewer high school students are reporting alcohol use before the age of 13 since 2003, from 25% in 2003 to 15% in 2011. Among middle school students, lifetime alcohol use decreased from 26% in 2009 to 20% in 2011.

Rates of cigarette use are declining among both high school and middle school aged youth. Both lifetime and current (past 30 days) cigarette use have been steadily declining among high school students since 2003 (lifetime use declined from 53% to 39%; and current use declined from 21% to 14%). Fewer high school students are reporting cigarette use before age 13 (15% in 2003 vs. 7% in 2011). And lifetime cigarette use in middle school students dropped from 15% in 2009 to 10% in 2011.

The latest statewide data on use of Other Tobacco Products such as cigars and smokeless tobacco show that they are gaining popularity among young people. The rate of tobacco use other than cigarettes was 17.6% among high school students in 2009 -- higher than the rate of cigarette use.

A number of other adolescent risk behaviors have also shown significant improvements since 2003. Fewer students reported driving after drinking (12% in 2003 vs. 7% in 2011).

More students reported eating breakfast every day 32% in 2003 vs. 37% in 2011), using seatbelts (84% in 2003 vs. 86% in 2011), and feeling there was a teacher in their school they could talk to about a problem (64% in 2003 vs. 71% in 2011).

However, many important risk areas remain statistically unchanged since 2003. Among high school students, there have been no significant changes in the percent reporting any lifetime sexual intercourse, condom use at last intercourse among sexually active youth, or ever having been/gotten someone pregnant. Also unchanged are high school students' reports of physical education, physical activity, binge drinking, suicidal thought and behaviors, mental health indicators, and obesity.

Many risk behaviors begin in middle school and there have been some improvements in 2011. Compared to 2009, fewer middle school students reported using alcohol in their lifetime (20% vs. 26%), smoking cigarettes in their lifetime (10% vs. 15%), and drinking one or more glasses of soda on the day before the survey (34% vs. 39%). Indicators that have remained unchanged in middle school since 2009 include marijuana use, other drug use, physical activity, and weight.

Some factors that help protect against risky behaviors have worsened. The percentage of students reporting having ever been taught in school about HIV/AIDS continues to decline significantly.

Information regarding several risk and protective factors is beginning to emerge. In 2011, new questions about cyber-bullying, violence initiation, and support from teachers were asked. Seventeen percent (17%) of high school students reported being a victim of cyber-bullying and 10% of high school students reported initiating cyber-bullying in the past year. Sixty-three percent (63%) of high school students agreed or strongly agreed that their teachers really care about them and give them encouragement and support.

More information about the findings from the latest YRBS and Youth Health Surveys can be found online in a couple of publications: "Health and Risk Behaviors of Massachusetts Youth, 2011 (<http://www.mass.gov/eohhs/docs/dph/behavioral-risk/yrbs-2011.pdf>) and "A Profile of Health Among Massachusetts Middle and High School Students, 2011 (<http://www.mass.gov/eohhs/docs/dph/behavioral-risk/2011-yhs.pdf>).

More information about the latest data on numerous perinatal health indicators and injury hospitalizations can be found in Part 5, Section E -- Health Status Indicators. Due to delays in the release of the 2010 data, we are not presenting updates on deaths (including infant mortality). We also do not have the finalized data from the 2011 BRFSS survey for updated information on other aspects of adult health. We expect all of those data updates to be available by the time our final application file is submitted in September.//2013//

5. Knowledge and understanding of health and wellness

The last decade has seen tremendous advances in the understanding and practice of health care and public health. Public health interventions focus increasingly on policy change and environmental strategies to influence factors contributing to poor individual health outcomes and poor population health status. As this change in understanding naturally influences MDPH priorities, a few critical themes are as follows:

- Life course perspective - Solely focusing on a disease or "body parts" is not enough. Innovative health care takes an increasingly longitudinal perspective: what happens in one stage of a person's life affects outcomes in future stages and the next generation. Two key components of the life course model include understanding the pathways and trajectories that lead to a multitude of health outcomes and a focus on the impact of early programming or exposure to risk that may have long-term health consequences. This new understanding includes the following:
 - o Social determinants of health including economic opportunity, community environment,

and social factors experienced in early childhood, childhood, adolescence, and adulthood plus individual physical and mental health factors affect population health outcomes including mortality, morbidity, life expectancy, and quality of life.

- o Maternal and family physical and mental health, practices, and living environment all affect an infant's health risk.
- o Early-childhood problems encountered and not addressed in formative years can have an impact on the person's future physical and mental health.
- o Life transition points (e.g. childhood to school, adolescence to adulthood, etc.) are sensitive periods of critical importance because of the number of changes that influence long-term health such as diet, activities, social network, built environment, and access to health care.
- o Life transitions, such as pregnancy and pre-pregnancy, offer critical teachable moments, where individuals confront significant change and are more open to guidance.
- o Certain populations will experience disproportionately adverse health outcomes based on differential access to resources and the presence of protective or risk factors that contribute to their health outcomes.

- Holistic perspective -- Related to the life course perspective, we should view health as more than a series of acute health conditions or particular diseases. We should consider the individual in a holistic manner, and consider such factors as financial status, family situation, community ties, and the built environment.

- o Mental health and oral health have emerged as strong components of overall well-being.
- o Stress and depression correlate with poor health outcomes for mother, infant, and family.
- o There are cohorts of the population, particularly adolescents, that exhibit a higher overall risk profile and are more likely to engage in multiple high-risk behaviors including drug use, smoking, unprotected sex, multiple sexual partners, and unsafe driving.

- Health Equity -- Disparities exist in health outcomes due to differential access to economic opportunities, community resources, and social factors. Economic opportunities may include adequate income, jobs, and educational opportunities. Community resources may include quality housing, quality schools, access to recreational facilities, access to healthy foods, transportation resources, access to health care, and a clean and safe environment. Social factors may include social network and support, leadership, political influence, organizational networks and racism. The role of public health is to establish public policy to achieve health equity and promote population based strategies which include:

- o Advocating for and defining public policy
- o Coordinating interagency efforts
- o Creating supportive environments to enable change
- o Collecting data, monitoring programs and conducting surveillance
- o Promoting population based interventions to address individual factors
- o Engaging with communities and building capacity

6. Learning and Influencing Behaviors

There is an important social component to learn new information or change existing behaviors. Advances in computing and electronic social media over the past several years have increased the opportunity to engage individuals and groups at a personal level. Additionally, MDPH will need to take advantage of new media to remain a leader in influencing health. Areas of special importance are:

- Segment specific marketing and emotional messaging -- It is not enough to make people aware and provide education. Most people, for instance, know that they should lose weight and exercise more. Targeted marketing with emotional appeal is crucial to changing high-risk behaviors.
- Social networking -- The Internet, especially social networking approaches, provides new avenues of public health outreach and engagement. In Massachusetts, 58% of women use the Internet regularly. The fastest growing age groups using social networking sites, such as Facebook, are those above adolescence (largely because so many adolescents are already on it). Some MDPH programs have already seen success leveraging blogs and social networking

sites.

- Essential Allies -- MDPH connects to many people but certain individuals or groups have a disproportionate influence on the actions and policy decisions of others. Strategies need to include connecting with these groups and people to communicate messages and engage stakeholders. For example, interviews with essential allies were an invaluable component of community outreach as part of the needs assessment process.

7. New State Initiatives & Programs

In addition to the changes outlined above, Massachusetts rolled out several critical initiatives and programs in the last five years that inform have an impact on today's programs. Highlights include:

- Children's Behavioral Health Initiative to improve screening, assessment, and treatment of behavioral health issues for those covered by MassHealth.
- Governor's Readiness Project to build a comprehensive, child-centric education system.
- Massachusetts Early Childhood Comprehensive Systems (MECCS) project to integrate systems of care, health, and education for young children and their families.
- Mass in Motion comprehensive action initiative to help fight obesity through policy change and public education. The initiative includes new regulations requiring school-based BMI screenings and reporting, menu labeling of nutritional information in chain restaurants, social marketing campaigns, a website and blog, and grants to municipalities to promote broad-based policy changes to improve opportunities for healthy eating and increased physical activity. Mass in Motion also supports the active state legislative discussion on banning junk food in schools and encouraging access to healthy snack items.
- Under the Mental Health Parity act that became effective in 2009, health plans are required to provide mental health benefits for all residents of Massachusetts and all insureds having a principal place of employment in Massachusetts.
- On April 30, 2010, the Massachusetts state legislature passed new anti-bullying legislation in part as a reaction to the suicide death of a fifteen year old. The comprehensive measure employs new strategies for adults, new supports for students and better communications among state agencies to prevent, report and effectively address issues related to bullying.

/2013/ Additional new initiatives are described below.

Leading the Way Home. The Massachusetts Department of Housing and Community Development, the City of Boston and the MDPH have begun working together on the Leading the Way Home (LTWH) program, a city-state collaboration that is offering Housing Choice Voucher Program (Section 8) housing assistance and ongoing support services to 500 families in Emergency Assistance shelters. This project is being supported by the Boston Interagency Council on Housing and Homelessness Network and the Boston Housing Authority (BHA).

Over the next year over 600 families will be referred to the BHA for eligibility screening, and ultimately leased up in units with rental assistance. In order to address the ongoing needs of the families participating in LTWH, MDPH will provide up to 18 months of stabilization services for each family from the time of lease up. Effective July 1, 2012, the MDPH will begin providing stabilization to families through the Leading the Way Home Program. MDPH will employ case managers who are experienced human service professionals with public health, community health, and child welfare experience. They will conduct comprehensive assessments and make referrals based upon the family's assessment.

Early Childhood Activities. In December 2011, Massachusetts was one of only nine states to receive a "Race to the Top -- Early Learning Challenge Grant" (RTT-ELCG). Massachusetts' successful application was largely the result of collaboration across state agencies, with significant MDPH involvement, and also with community leaders to develop a comprehensive, aggressive plan for a well-coordinated system of education and care for

young children. Core to this plan is strategic and intentional collaboration across state family and child-serving systems, reflecting the shared responsibility of childcare, health, housing, education, child welfare, mental health, and economic development to improve outcomes for children.

On May 14, 2012, to advance strong partnerships across these multiple domains, the Commissioner for EEC, with planning support provided by DPH staff, hosted a one day retreat entitled "Fulfilling the Promise: Building Strong Inter-Agency Partnerships for the Success of Young Children." This retreat served to engage state leadership and initiate planning and a decision-making process for action. Delegations from 16 state agencies attended with over 55 leaders participating, including state representatives, the Secretary of Education, Executive Directors, and Commissioners as well as top key managers whose roles are central to the implementation of "Race to the Top" plan. Substantive source materials including a summary of the grant, research on brain and child development, effective education and care system building and collaboration were provided to retreat participants.

During the retreat, all agencies identified strengths / assets that can be marshaled going forward in support of grant implementation. These strengths/assets fall into the following themes: data sharing on families and children with multiple risk factors; linked service delivery / response; and hared professional development. Specific action steps were also developed that emphasize: cross-agency data sharing (with the goal of a universal consent form and process for all child serving or child impacting agencies by 12/12 and cross-agency professional staff. Other long range themes that emerged included Connected Workforce Development and Strengthening Family Support.

During the past year MDPH staff have also been instrumental in the creation, led by Early Education and Care Commission Sherri Killins, of the Young Children's subcommittee of the Children' Readiness Cabinet. The goal of this body is to affirm and support cross agency initiatives and on-going development of comprehensive systems of care for young children and to assure they arrive at public school healthy, prepared and ready to learn.

//2013//

/2013/ Data Sharing Activities. Considerable activity has occurred in FY12 and will continue into FY13 focusing on cross-secretariat and cross agency data sharing. The recently signed state budget includes language, that charges the MDPH to work with the Department of Early Education and Care and the Department of Elementary and Secondary Education and the Executive Office of Education on a data sharing pilot program to assign a state assigned student identifier to children participating in early intervention programs with the goal of tracking and evaluating educational and developmental outcomes for those children, improving delivery of services and determining any special education or cost savings associated with the early intervention program. It provides further, that the participation of a family in any pilot program shall be contingent upon informed consent. All parties are charged with reporting to the secretary of administration and finance, the house and senate committee on ways and means, and the joint committee on education by October 1, 2012 on a mutually agreed upon definition of informed consent and the process by which informed consent will be obtained. In addition, all parties will report by Spring 2013 on the progress made on implementation of the pilot program, including the criteria used for selecting sites and preliminary implementation plans for the assignment of state assigned student identifiers to children receiving early intervention services. Further all parties are charged with developing a timetable for full implementation of the pilot program including resource needs to meet the proposed timetable, articulating a plan for obtaining informed consent from families receiving early intervention services, presenting the number of state assigned student identifiers that have been assigned to date, if applicable, and providing recommendations on how the MDPH and the agencies of the executive office of education can rigorously evaluate the effect of early intervention

services on the future special education needs of program participants. //2013//

Shifting focus to population and infrastructure building

Massachusetts public health has continually moved to building population and infrastructure level services to have the largest possible impact and ensure systems are available to meet the growing needs in the state. MDPH has maintained direct and enabling services where necessary to fill gaps in service provision and be a complement to other resources available. Massachusetts Maternal and Child Health Programs assess capacity to meet the needs of the MCH population on these three levels:

1. Direct and enabling services, which include one-on-one patient care, medical services, and services such as insurance, outreach and other supports that help people access and utilize available care.
2. Population-based services, which are preventive and personal health services developed for a whole population, such as screenings of all newborns and educational materials for the general public.
3. Infrastructure-building services, which are the foundation for MCH activities such as the state legislative and regulatory framework for MCH, partnerships to improve comprehensive systems of care, and information systems.

Priorities and the Process to Determine Priorities

The process to develop the priorities for the needs assessment is similar in principle to how the MA Title V agency develops priorities on an ongoing basis. The challenge of the Title V Director will always be to balance the needs of the MCH populations with the resources, including expertise and political will, to effect change in the state that improves outcomes.

The Title V management team uses the following list of principles to guide the ongoing prioritization process:

- Promote health and well-being of MCH populations.
- Promote an understanding of the Life Course Perspective and the impact of the Social Determinants of Health within all programs.
- Promote continuity of care among all populations.
- Address health equity by targeting the increasingly diverse MCH populations in Massachusetts.
- Ensure community engagement through essential allies and others.
- Focus on family involvement, including fathers.
- Target interventions as early as possible and focus on teachable moments.
- Be nimble in awareness of and response to emerging trends, both fiscal and scientific.

The Title V management team then applies a screening process that leverages all available data and evidence, and incorporates the subjective points of views of stakeholders through surveys, interviews, and focus groups. Priorities reflect the knowledge gained from existing and past MDPH programs and activities.

In simple terms, the team uses a two-dimensional decision criterion:

- 1) What are the relevant factors affecting the likely impact?
- 2) What is the feasibility of success?

"Relevant Factors" include:

- consideration of the number of people affected (incidence and prevalence)
- the degree of importance for quality of life and long-term outcomes
- prevention based on current research or evidence
- socio-economic, cultural, or geographic disparities
- whether actions based on the priority increase or enhance collaboration with other state and private agencies.

"Feasibility" includes the following considerations:

- the level of MDPH competency in subject matter
- political and organizational will (internal and external champions)
- resource availability and relative cost
- leadership vs. follower position for particular issues
- relevance to the core mission of MCH and MDPH
- availability of government and community partners
- availability of resources to advance the work of MDPH
- presence of synergistic effect among multiple priorities (e.g., screening for mental health can include screening for substance use and domestic violence).

Success depends on both identifying how each priority is relevant to every individual service program and identifying how to best leverage the wide number of ongoing collaborations across MCH Title V and with other state and local agencies and programs. Massachusetts Title V does not have the scale to be successful in these priorities by acting alone. Success will depend on working in concert with other agencies and programs to ensure the priorities of MCH are the priorities of others in the state working for and with the MCH populations.

An attachment is included in this section. IIIA - Overview

B. Agency Capacity

The Bureau of Family Health and Nutrition (BFHN), in the Massachusetts Department of Public Health (MDPH) is the Title V Agency for the Commonwealth of Massachusetts. MCH-related program areas both within the Bureau and in other Bureaus in the Department are listed and briefly described in a Table organized by the MCH Population Groups that they primarily address. This table is part of a Word document that is the attachment to this Part III, Section B (Agency Capacity). The Table is called "MCH-Related Programs, Brief Descriptions, and Services Provided" and is the first 11 pages of the file. /2012/ An updated Table is again attached as is the first 11 pages of the file.//2012// ***/2013/ An updated Table is again attached as the first 11 pages of the file.//2013//***

The Bureau is committed to protecting and improving the health status, functional status, and quality of life of Massachusetts residents across the lifespan, with special focus on at-risk populations, low-income groups, and cultural and linguistic minorities. The programmatic divisions through which the Bureau carries out its mission are described in the next section, "Organizational Structure."

An attached Figure displays BFHN and other DPH MCH partnership programs and activities schematically in relation to the levels of the "MCH Pyramid." This Figure is in the Word document that is the attachment to this Part III, Section B (State Agency Capacity); it is called "The MCH Pyramid Core Public Health Services Delivered in Massachusetts by MCH" and is the last page of the file. /2012/ An updated Figure is again attached and is the last page of the file.//2012// ***/2013/ An updated Figure is again attached and is the last page of the file.//2013//*** The pyramid includes the core public health services delivered by MCH agencies hierarchically by levels of service from direct health care services (the tip of the pyramid) to infrastructure building services (the broad base of the pyramid). The Figure lists both generic functions and services carried out by MCH agencies that BFHN provides or assures, as well as specific Massachusetts programs and initiatives. Many programs carry out activities at more than one level of the Pyramid (e.g. primary care service providers also assist families with enrollment in WIC or offer other enabling services as well; population-based lead screening programs also provide direct client case management for children found to be lead poisoned). However, for this purpose, each program has been shown only at the level of the Pyramid that represents its primary or dominant focus based on the MCHB definitions for levels of services.

Within the Bureau of Family Health and Nutrition (BFHN), which is led by Ron Benham, the

state's Title V director, are core programs to MCH health and development including the Nutrition Division with WIC, the Division for Perinatal, Early Childhood, and Special Health Needs with EI and the CYSHCN Program, and the Office of Data Translation. Through these programs the Title V agency helps guide the early developmental needs of children, youth with special health needs, and women near the time of childbirth. Several key collaborative relationships are directly assured by the location of other MCH-serving programs within the BFHN. In addition to WIC, these include Early Intervention / Part C of the Individuals with Disabilities Act (IDEA), and Ryan White Part D.

Within the Department of Public Health, the Title V Director and key program staff in BFHN collaborate closely with the Medical Director of the Department, the Bureaus of Community Access and Promotion Substance Abuse Services, Emergency Preparedness, Environmental Health, Health Care Safety and Quality, Health Information, Laboratory Sciences, and Infectious Disease Prevention, Response and Services (which includes communicable disease prevention and HIV/AIDS programs), the Office of Health Equity, and the Office of Healthy Communities (which supports the department's efforts to build and support better local and regional public health infrastructure and systems of care).

A number of Federal-State MCH Partnership programs and responsibilities reside in BCHAP, the Bureau of Community Health Access and Promotion, under Director Jewel Mullen. /2012/ The name and leadership of BCHAP changed this year. The new name of the Bureau is Community Health and Prevention and the new director is Cheryl Bartlett. //2012// These include family planning services, school health, primary care, adolescent health, and violence and injury prevention programs, along with chronic disease prevention and health promotion programs.

MDPH also collaborates as a sister agency within the cabinet-level Executive Office of Health and Human Services (EOHHS) with other state agencies in regular meetings, cross-agency program development, workgroups and special taskforces. Other agencies within EOHHS include the Department of Transitional Assistance (welfare), the state Medicaid agency, the Department of Children and Families, the Department of Mental Health, the Department of Developmental Services, Department of Youth Services, Commission for the Blind, Commission for the Hard of Hearing, Executive Office of Elder Affairs (which includes long-term care for children as well as adults and elders), and the Division of Health Care Finance and Policy.

Beyond EOHHS, Title V has strong linkages with the Executive Office of Education (EOE), including the Department of Elementary and Secondary Education (DESE) and the Department of Early Education and Care, with many collaborative, systems-building efforts underway. Other linkages to promote better systems beyond EOHHS include the Department of Public Safety, the Department of Housing and Community Development, and others. DEEC is responsible for the administration of all public and private early education and care programs and services in the state.

The Director of the Bureau of Family Health and Nutrition, who is the Title V administrator, holds a senior leadership position within MDPH and reports directly to the Commissioner of Public Health. He is integrally involved in collaborations and decision-making regarding both internal and cross-agency program development that affects MCH populations. He also collaborates with and seeks input from professional organizations, consumer representatives, advocacy groups, and community providers, as well as participating on multiple committees and taskforces addressing MCH issues in the state.

/2012/ A number of these collaborative relationships are being strengthened and expanded with the advent of the ACA-funded Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program overseen by HRSA and ACF. The Governor named the Department of Public Health, through the Bureau of Family Health and Nutrition, as the lead agency for Massachusetts. A Task Force guiding the projects of the MIECHV program is comprised of representatives from a number of state agencies: Department of Early Education and Care, Executive Office of

Education, Department of Transitional Assistance, Department of Children and Families, the Children's Trust Fund, and the state Medicaid program, MassHealth.

The Governor has proposed a reorganization of the state Executive Office of Health and Human Services to co-locate a number of child-serving agencies into a new agency, the Department for Children, Youth and Families. This department would include the consolidation of two existing state agencies -- the Department of Children and Families (the state child welfare agency) and the Department of Youth Services (the state Juvenile Justice agency) -- along with additional children and youth programs. From BFHN, programs under consideration for transfer to the new agency are Children and Youth with Special Health Care Needs programs, Early Intervention, and home visiting programs. Other MDPH services under consideration include youth-focused substance abuse programs and services. The timing of the reorganization and its extent have not yet been finalized. The Title V Bureau Director has been actively involved as the MDPH Commissioner's designee to the Secretariat-level planning group; the BFHN Director of Family Initiatives will also become increasingly involved in FY12. //2012//

//2013/ A proposed reorganization of children serving agencies did not occur in FY12 and the focus of reform has shifted. Beyond the discussion of collapsing several agencies into one, significant efforts focused, and will continue to focus in FY13, on how information and data can be shared across agencies to help children and families achieve their optimal outcomes. Impacted agencies, both within and external to government, as well as family members and legal advocates have been engaged in these discussions. It should be noted that for many the key questions to be answered are what data should be shared, with whom, and how will child/family confidentiality rights be protected?

Additional efforts that will occur in FY13 will focus on the role of family support centers and the assistance they can provide to families to assist in the navigation of the Commonwealth's human service system.

In addition to receiving formula funding for MIECHV, which is now called the Massachusetts Home Visiting Initiative (MHVI), MDPH also received an expansion grant to implement evidence-based home-visiting programs across 17 communities and enhance the services provided to families in these communities through their home-visiting program. Some of the enhanced services include Moving Beyond Depression, which provides in-home cognitive behavioral therapy to clinically depressed parents; Parents Together which is an evidence-based strategy for providing group services to new parents to decrease social isolation; the New Parent Project that promotes communication between adults providing care for young children to enhance positive parenting; and adding a nursing component to all evidence-based home visiting programs. To develop and implement this expansion, MDPH has established a leadership team to oversee all activities, and multiple implementation teams including 1) data and evaluation; 2) model fidelity; 3) training; 4) systems and sustainability; and 5) universal one-time home visit. State agencies represented on these teams include the following: Department of Early Education and Care, Executive Office of Education, Department of Transitional Assistance, Department of Children and Families, the Children's Trust Fund, and the state Medicaid program, MassHealth. Also included in these teams are three evaluators: Tufts University, the Donahue Institute of UMass, and Harvard-Catalyst. Community partners also participate in each of the implementation teams, and on the leadership team. //2013//

Our MCH Priorities and State Performance Measures clearly reflect the systems development and partnership philosophies articulated above and have been developed with the Massachusetts health care system context in mind.

There are no statutes in Massachusetts directly related to the establishment or operation of a Title V program as defined by MCHB/HRSA. There are, however, a myriad of statutes and regulations that address issues related to MCH and CSHCN. Many of these have been

referenced in the Needs Assessment section and in the NPM/SPM annual report narratives. Recent examples of statutes and regulations related to MCH priorities, all of which involved leadership or significant input by Title V, include the junior operator law, primary child passenger restraint law for children under age 14; expanded birth defects monitoring and surveillance regulations, postpartum legislation, expanded newborn blood screening regulations, expanded public health practice for dental hygienists, breastfeeding in public places, required periodic measurement of BMI in schools, reducing bullying in schools, and safe driving legislation that bans texting while driving for all drivers and cell phone-use by junior operators. Additional pending bills, which may pass before the end of the current legislative session, include ATV regulations, and sports concussion prevention.

/2012/ The sports concussion prevention bill was passed and regulations for its implementation were approved by the Public Health Council in June 2011; they will go into effect with the new school year. //2012//

/2013/Under the leadership of Representative Ellen Story and in collaboration with the Massachusetts Maternal & Infant Mental Health Advisory Group as well as a diverse group of advocates across the Commonwealth, legislation was drafted specific to postpartum depression and a bill was filed in 2009. On August 19, 2010, Governor Deval Patrick signed into law An Act Relative to Postpartum Depression, Chapter 313 of the Acts of 2010.

This legislation has two primary components: 1) establishing a PPD Legislative Commission and 2) authorizing the MDPH to develop a culture of awareness, de-stigmatization, and screening for perinatal depression. MDPH is represented on the Commission by the BFHN MCH Director, and is charged with assessing current research on postpartum depression; reviewing current PPD screening policies and practices; assisting MDPH in developing educational materials and referral lists; designating validated screening tools for use by providers; assisting MDPH in identifying state funding and apply for federal funding; and filing an annual legislative report. MDPH is charged with developing standards for effective PPD screening; making recommendations to health plans and health care providers for PPD screening data reporting; issuing regulations that require health plans and health care providers to annually submit data on screening for postpartum depression; and issuing an annual summary of the activities related to screening for postpartum depression including best practices and effective screening tools.//2013//

The Massachusetts Title V program has historically been a leader in the development of a statewide system of services that reflect the principles of comprehensive, community-based, family-centered care for CSHCN. An extensive review of where we stand on the MCHB-defined four constructs by which to assess the service system for CSHCN and state involvement with it is included in our Five-Year Needs Assessment (Section 4.D3). /2012/ A stand-alone version of the Constructs section, with annual updates as appropriate, will be provided as an attachment to the Needs Assessment Summary (Section II.C.) in the interval until the next 5-year needs assessment.//2012// ***/2013/The most recent updates to the Constructs section is again provided as an attachment to the Needs Assessment Summary (Section II.C.) //2013//***

An attachment is included in this section. IIIB - Agency Capacity

C. Organizational Structure

The Bureau of Family Health and Nutrition (BFHN), in the Massachusetts Department of Public Health (MDPH) is the Title V Agency for the Commonwealth of Massachusetts. The BFHN is a free-standing unit reporting directly to the Commissioner of Public Health. A sister Bureau within MDPH, the Bureau of Community Health Access and Promotion (BCHAP) ***/2013/(now named the Bureau of Community Health and Prevention)//2013//***, includes a number of MCH-related programs and initiatives. Staff of both Bureaus work closely together on many initiatives, including the 5-Year Needs Assessment, priority setting, and this annual application and report. See Section III. B. (Agency Capacity) for additional information about this organizational structure.

The Department of Public Health is part of the Executive Office of Health and Human Services. (See the organizational charts in the attachment to this Part III, Section C. (Organization Structure)). Central functions such as legal, human resources, and information technology have been centralized at the EOHHS level. JudyAnn Bigby, M.D. is the Secretary of Health and Human Services under Governor Deval Patrick and John Auerbach is Commissioner of Public Health.

Ron Benham currently serves as both the Title V director and state CSHCN contact person. We plan to recruit and hire a new CSHCN director management position; this process has been delayed at least until the Fall due to Secretariat-wide freezes on new management hiring or vacancy replacements. Karin Downs, Assistant DPECSHN Director for Clinical Affairs, serves as the state Title V MCH Director. /2012/ Posting and hiring for the new CSHCN director management position was delayed again during FY11 as budgetary concerns continued to restrict new hiring. We are cautiously hopeful that the posting for the position will be approved and move forward during FY12. //2012//

/2013/ The position was posted during FY12. Our selected candidate, however, chose to accept another job. The vacancy has been posted again, with additional outreach to wider audiences. //2013//

The Bureau of Family Health and Nutrition is committed to protecting and improving the health status, functional status, and quality of life of Massachusetts residents across the lifespan, with special focus on at-risk populations, low-income groups, and cultural and linguistic minorities. The Bureau includes the following divisions and offices:

- Division for Perinatal, Early Childhood, and Special Health Needs (DPECSHN)
- Nutrition Division (including WIC)
- Office of Data Translation
- Massachusetts Birth Defects Center

The Bureau of Community Health Access and Promotion **/2013/ (now named Community Health and Prevention)//2013//** includes:

- Division of Primary Care and Health Access (DPCHA)
- Division of Prevention and Wellness (DPW)
- Division of Violence and Injury Prevention (DVIP)
- Office of Statistics and Evaluation

Both Bureaus have internal support centers for administration, policy, and planning.

A reorganization within BFHN is under active consideration, but not finalized. Under this plan, DPECSHN would be split into three smaller divisions: Perinatal and Early Childhood; Early Intervention; and Children and Youth with Special Health Needs. This would create more manageable units that would each report to the Bureau Director. /2012/ This new organizational framework has now been finalized, and implementation still awaits recruitment of management positions to lead the CYSHN and Early Intervention divisions. In the interim, a new mid-level management position for Early Childhood has been approved and should be posted shortly. //2012//

/2013/ The larger reorganization is still on hold pending the recruitment of a director for CYSHN. The Early Childhood Program Director management position was posted and is now filled by Kate Roper, who had been working in the Bureau in a similar role. We are in the process of upgrading the Office of Data Translation Director position (Dr. Hafsatou Diop) from an Epidemiologist II to a Management VI position. //2013//

For Block Grant purposes, all MCH services and initiatives are reported in an integrated manner and staff and leadership of BFHN, BCHAP, and other key MDPH Bureaus and programs continue to work closely together to address common issues and cross-cutting initiatives. The resulting integration of needs assessment, planning, program implementation, and evaluation can be seen throughout our 5-year needs assessment and the program activities and accomplishments

described in this Application and Annual Report. The BFHN retains overall responsibility for the Title V program and funds, including final submission of the 5-Year Needs Assessment, Application and Annual Report; and sign-off on the MCHS Block Grant budget.

/2012/ The Governor has proposed a reorganization of the state Executive Office of Health and Human Services to co-locate a number of child-serving agencies into a new department. This department could include several major Title V-funded programs, including Services for Children and Youth with Special Health Care Needs, Early Intervention, and home visiting programs. The timing of the reorganization and its extent have not yet been finalized. See Section B. above for more information. If this reorganization and program transfer does occur, it will substantially affect the management and oversight of Title V-funding programs, staff, and services for mothers and infants and CYSHCN. Bureau CYSHCN staff are participating in the planning process, but we are uncertain at this time how the reorganization will affect the integration and coordination of Title V services across the lifespan. //2012// **/2013/ A reorganization at the agency level is no longer under active consideration. See the 2013 update to Section B above for information about the current focus of reform, in which Title V is an active participant. //2013//**

In addition to its central office, the Bureau maintains staff in the five MDPH regional offices locations. Many of these staff, such as FOR Families home visitors, and care coordinators for CSHCN provide direct services to individuals and families. Others work closely with BFHN programs, providing regional and local training and technical assistance, information and referral to services, coordination of services for families, performance monitoring, and other capacity building activities; these include the regional Early Intervention specialists. Among the staff are the Family TIES parent staff. /2012/ At this writing, the future of the FOR Families program and its regional staff resources are uncertain after about January, 2012, due to both funding cuts at the state agency supporting them (DHCD) and a changing approach to prevent homelessness by the Commonwealth. In addition, the potential state reorganization of services for children and families (see above) may affect the disposition and locations of our care coordination and Family TIES staff resources. //2012// **/2013/ The future of the FOR Families program is more stable at this time. Funding for FY13 has been committed by DHCD and we are working with them on a new initiative, Leading the Way Home, whose case management staff will also work out of some of the MDPH Regional Offices. (See 2013 updates to Section III.A. State Overview above for more information about the Leading the Way Home program.) The MDPH components of the new Race to the Top Early Learning Challenge initiative will also include new regionally-based public health nurses, although they will be co-located in Department of Early Education and Care (EEC) regional offices. //2013//**

Regional Offices report through a department level Office of Local Health Services, under the oversight of a Senior Policy Advisor to the Commissioner. BFHN regional staff work collaboratively with the Department's regional managers and the related Office of Health Communities, under whose leadership MDPH works with communities to build and enhance public health infrastructure at local and regional levels and to develop systems of care that are responsive to the diverse needs of community members. For example, the Department is working very actively to create and sustain more regional local health units. Without a functioning county system, individual local boards of health exist at the city/town level (351).

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

As of June, 2010, approximately 224 full-time equivalent (FTEs) employees throughout the Department work on Title V Partnership programs; of these 114 FTEs are paid from Title V Partnership funds. The rest are paid from other MCH-related federal accounts. Approximately 23 of the total are usually based in the MDPH regional offices or other off-site locations (such as physician practices); the others work out of our central office in downtown Boston. These staff include a wide range of disciplines and professional expertise, including an extensive staff of

epidemiologists and data specialists devoted to MCH-related activities.

The number of FTE staff paid directly by the MCH Block Grant is expected to be 91 for FY11 (down slightly from FY09), and they now represent approximately 41% of all FTEs and 80% of all Partnership FTEs. During FY09, state fiscal rules regarding payroll positions on MDPH state accounts were relaxed and a number of staff working on MCH-related programs were transferred from the MCH Block Grant (and other federal accounts) to various state accounts. This has reduced our reliance on federally-funded positions without affecting the total workforce. It also saves us money, as fringe benefits and indirect costs for state account positions are paid from a separate reserve rather than from the payroll account, as federal positions are charged. In addition, on-going efforts to convert all consultant positions (which do not come with benefits) to regular payroll positions have enabled us to transfer a number of consultants into equivalent positions. This has provided better benefits and employment rights to the individuals and helps in retaining these valuable staff. The most recent change to staffing arrangements has been the consolidation of all EOHHS Information Technology staff and functions at the Secretariat level and the creation of a centralized new state account into which state funds previously in MDPH accounts were transferred through the budget process. For federally funded positions (of which there were 6 on the MCH Block Grant), the staff are now on the central state IT account but the department is charged for their costs through a chargeback mechanism. Thus the FTE count at MDPH is lower, although the staff are still working on the same related functions and the costs are accounted for differently.

/2012/ As of June, 2011, approximately 212 full-time equivalent (FTEs) employees throughout the Department work on Title V Partnership programs, with 114 FTEs of these paid from Title V Partnership funds. Approximately 27 of the total are usually based in the MDPH regional offices or other off-site locations. The number paid directly by the MCH Block Grant is expected to be 94 for FY12. This total includes 2 vacant management positions we hope to fill during the year as well as portions of several positions that have been moved back onto the MCH Block Grant as federal funding cuts to discretionary grants have reduced the FTEs that they can support. They will represent 44% of all FTEs and 82.5% of all Partnership FTEs. The increase in these percentages reflect the relative stability of MCH BG funding to date compared with either state partnership or other federal funding. All of these projections are subject to change based on the final FY12 Block Grant funding level and any further cuts in state funding. //2012//

/2013/ As of June, 2012, approximately 217 full-time equivalent (FTEs) employees throughout the Department work on Title V Partnership programs, with 114 FTEs of these paid from Title V Partnership funds. Approximately 26 of the total are usually based in the MDPH regional offices or other off-site locations. The number paid directly by the MCH Block Grant is expected to be 92 for FY13. This total includes two vacant management positions we hope to fill during the year. They will represent 42% of all FTEs and 81% of all Partnership FTEs. These totals and percentage distributions are essentially unchanged from FY12. All of these projections are subject to change based on the final FY13 Block Grant funding level, any further cuts in state funding, or receipt of additional grants during FY13. //2013//

Brief biographical sketches of the Title V Partnership senior management team are available in the Word document attached to this section. The biographies are the first section of the Attachment.

Key data capacity elements are summarized in Health Systems Capacity Indicator #09. (See Form 19.)

Not counting short-term positions and service on task forces, the Bureau employs over 16 ***/2013/ 14 //2013//*** parents who represent approximately 12 full-time equivalent staff. This includes EI Parent Leadership Project, Family TIES, and Universal Newborn Hearing Screening staff. One part-time position has remained vacant for two years and may remain so due to funding

limitations. ***/2013/ Two part-time positions have remained vacant for two years but we are expecting to fill both of them in the coming fiscal year. //2013//***

Flexibility in both work hours and locations has enabled us to hire and retain this large group of committed and skilled people. Family TIES Coordinators work out of the regional offices and are the voices behind the statewide 1-800 number for families with children with special health care needs. More information on our extensive parent involvement initiatives is provided in Section II.B. above in our discussion of "Constructs of a Service System for CYSHCN," as well as throughout our reporting on Performance Measures. The multiple types of roles that they carry out are also displayed visually in a Figure included in the Word document attached to this Section.

Family members continue to report a strong commitment from the CYSHCN Program to create opportunities for involvement. Stipends for participation are always given. Families receive a high level of training and mentoring that facilitates participation. The CYSHCN Program encourages and supports family members to attend local, statewide, and national conferences and meetings. Family members of CYSHCN are valued and sought for their experience and expertise as parents. However, families still identify the need to increase diversity of families involved in Title V activities. ***/2012/ Family staff and those in the community report a great improvement in outreach and engagement of families from diverse cultures. This increase is the result of extensive targeted outreach, training and relationship building to community based organizations serving families from underserved populations. CYSHCN staff continue to address cultural competence and access challenges when working in the community with diverse groups.//2012//***
/2013/ Despite an increase in numbers of diverse families reached, family staff still identify a need to address cultural norms that keep families from diverse backgrounds from active participation in Title V activities. //2013//

Form 13 - "Characteristics Documenting Family Participation in CYSHCN Programs"

In scoring Form 13 for this application, families reported satisfaction with the opportunities for involvement and partnership; scoring remained the same at 16 (of a total possible of 18). They noted continued improvement in attracting and involving more bi-lingual, bi-cultural parents to work with us, giving us a score of "2+." They expressed feeling increased confidence that we are on a path to meet the needs of families from diverse cultural backgrounds. As always, they remind the state Title V program that although we are doing an excellent job of involving families there are always ways to do even more.

/2012/ Scoring increased to 17. Family staff expressed feeling increased confidence that we are doing a better job of engaging families from diverse cultural backgrounds. In addition, family staff are making presentations about their work and the goals of family engagement to their colleagues at the regional level. This has resulted in several new community-based public health collaborations, particularly in meeting the needs of refugees and immigrants who have children with special health care needs. Family staff are very helpful in identifying challenges, such as how to effectively mentor when language barriers exist and how to ensure that families in the community understand the Block Grant and that their input influences program development.//2012//

/2013/ The Form 13 score remained at 17 out of a possible 18 points. Family staff again noted strong satisfaction with involvement in CYSHCN elements of the Block Grant, as well as continued improvement in reaching more bi-lingual, bi-cultural parents to work with us. //2013//

An attachment is included in this section. IIID - Other MCH Capacity

E. State Agency Coordination

The BFHN views both intra-agency and interagency coordination as being essential to the achievement of its mission on behalf of improved maternal and child health. The Bureau

maintains and promotes extensive networking and systems development relationships at the national, state, and local levels. These relationships include provider, non-profit, and other organizations; advocacy groups; coalitions, task forces, and community groups; other state agencies and governmental groups; universities and colleges; and internal MDPH working groups.

The capacity to work with, influence, and promote comprehensive provider-based service systems continues to include not just hospitals and community-based providers such as community health centers, but the private providers, tertiary and specialty hospitals, professional associations such as AAP, ACOG, and the Massachusetts Medical Society, payers and insurers, universities, schools of public health, and many others.

Many of the activities carried out through these relationships are noted throughout the Annual Report and Annual Plan sections of this document as they related to specific performance measures or Title V priorities. The Bureau works with a broad base of constituency groups many of whom relate to specific populations or issues. The extensive Massachusetts Title V collaborative relationships and network of resources, categorized by type of agency/organization and including both public sector agencies and private sector organizations and institutions, is available in the Word document that is the Attachment to this Section, "Massachusetts Federal-State MCH Partnership: Key MCH-Related Relationships." ***//2013/ An updated document is again attached to this Section. //2013//***

Collaboration with EOHHS and Medicaid

BFHN, as the Title V agency, also promotes collaboration and coordination across most programs and agencies within EOHHS. Through multiple work and advisory groups, the agency supports the wide breadth of needs of the MCH population. This cross-collaboration becomes more important with increasing understanding of the needs across the lifespan of the MCH population, including the impact of economic security, the built environment and the importance of paternal health and involvement in child development. The key EOHHS sister agency relationships to promote MCH include MassHealth (the Massachusetts Medicaid Program); the departments of Children and Families, Mental Health, Developmental Services (previously Mental Retardation), Transitional Assistance, Youth Services, and Elder Affairs (which oversees long-term care for all ages); Health Care Finance and Policy; Massachusetts Rehabilitation Commission, Mass. Commission for the Blind, Mass. Commission for the Deaf and Hard of Hearing, and the Office of Refugees and Immigrants. These agencies include such key services as SSI, vocational rehabilitation, developmental disabilities programs, and autism services for those over age 3. BFHN also participates in several Secretariat-wide efforts to assure better and more comprehensive systems of care, including the Children's Behavioral Health Initiative, the Patient-Centered Medical Home Initiative, and two complementary SAMHSA grants (MassLAUNCH located at MDPH) and MYCHILD at EOHHS).

The Bureau continues a history of working with the various components of the Office of Medicaid, within EOHHS, even as Medicaid (MassHealth) has undergone numerous reorganizations and realignments over the last several years. We continue to work to assure that there is a comprehensive and integrative approach in the outreach, enrollment and services provided to MassHealth, including CommonHealth for CYSHCN, recipients. This has included involvement in waiver development, MMIS purchasing, enrollment functions and development of standards of care and quality initiatives. The Bureau strives to maximize Federal reimbursement mechanisms including FMAP (Federal Medical Assistance Percentages) claiming and Municipal Medicaid opportunities. One of the key collaborative initiatives over the last five years was the Massachusetts Special Commission on After School and Out of School Time, a legislative commission that produced a comprehensive report and proposal for the Commonwealth to better address after school and extended learning needs in 2008.

Another is the on-going implementation of the EOHHS response to the Rosie D class action lawsuit. As a result of the settlement of the lawsuit, universal behavioral screening for children on

Medicaid at each EPSDT visit was implemented in January, 2008, utilizing an approved screening tool. This response has evolved into the Children's Behavioral Health Initiative, (CBHI), an EOHHS interagency initiative that will improve how Massachusetts oversees, provides and coordinates children's behavioral health services. It will help ensure the early identification and screening of behavioral health issues in children, and expand and integrate Massachusetts state services into a comprehensive, community-based system of care, to ensure that all families and their children, not just those on Medicaid, with significant behavioral, emotional and mental health needs obtain the services necessary for success in home, school and community. The Title V Director and other MDPH staff actively participate in the CBHI and the development and implementation of this critical policy initiative; the Title V Director serves on the both the Executive and Implementation Committees.

The BFHN has also had on-going discussions with MassHealth related to early intervention services, autism services for children birth to 3, and the need for subacute and respite services for children with significant medically complex health. These have led to some major policy and services changes, including the agreement for MassHealth to reimburse for the services of Early Intervention developmental educators for its enrollees; previously MDPH had to cover these services for MassHealth clients; the shift makes the services eligible for FMAP.

Massachusetts now has a legislative mandate for MassHealth to establish a medical home demonstration project including: a restructured payment system to support primary care practices using a medical home model; support for practices in their transformation; and agreement to work with other Medicaid payers and other stakeholders. Under the legislation a Medical Home is "a community-based primary care setting which provides and coordinates high quality, planned, patient and family-centered health promotion, acute illness care, and chronic condition management." The Massachusetts Patient-Centered Medical Home (PCMH) Initiative Council (PIC) was created to advise EOHHS in its role as convener and overseer of the PCMH Initiative. The Council is tasked to recommend a design, including payment models and practice transformation strategies, to support a large-scale roll-out of public-private multi-payer medical homes across the Commonwealth. Membership on the council includes payors, purchasers, clinicians, and researchers to support all levels of redesign. Redesign includes practice redesign, consumer engagement, and clinical care management and care coordination. Title V participates in this process, emphasizing our experience with implementing medical home for CYSHCN and the need to include children and families in program development going forward.

/2012/ BFHN staff have been actively engaged with the MassHealth program in crafting language for a Medicaid waiver allowing for the creation of a billable service unit for toddlers with a diagnosis in the Autism Spectrum. Approximately 40% of more than 1,400 infants and toddlers being served in FY11 are MassHealth enrollees. At present, all costs for autism services for these children are borne by MDPH.//2012//

/2013/ In FY12 MassHealth (the Massachusetts Medicaid program), in a collaborative effort to diversify funding streams and to ensure appropriate access to evidenced-based intervention to young children with ASD across the Commonwealth, began a process to apply to the Centers for Medicare and Medicaid Services (CMS) for a demonstration waiver to provide medically necessary Applied Behavioral Analysis-based treatments services to MassHealth eligible children. Simultaneously, discussions around offering these services as an EI benefit were initiated with private health insurers. The CMS waiver to provide highly structured, evidence based, individualized, person-centered treatment programs that address the core symptoms of ASD was approved and rolled out on July 1 2012, as did coverage for intensive behavioral services by a number of private health plans. Positive outcomes on both fronts may provide a model for other states struggling to meet the needs of young children with ASD.

The above described effort was undertaken as the number of children diagnosed with ASD has grown significantly in the past decade, the costs of this program have consumed an

increasing percentage of the Early Intervention budget. While the funding to support Early Intervention services in MA is quite diversified and includes significant support from private and public health insurers, the cost of intensive behavioral services for children with ASD have been borne exclusively by MDPH. //2013//

Other Collaborations

Another collaboration of note is our active participation on Birth to Three Task Force formed by EEC. MDPH staff sit on all Task Force committees to represent health issues. The Task Force itself is a subsection of the Governor's School Readiness Project, a major policy initiative.

Beyond EOHHS, Title V has strong linkages with the Executive Office of Education (EOE), which includes the Department of Elementary and Secondary Education (DESE) and the Department of Early Education and Care, with many collaborative, systems-building efforts underway. Other linkages to promote better systems beyond EOHHS include the Department of Public Safety, the Department of Housing and Community Development, and others.

/2013/ In December 2011, Massachusetts was one of only nine states to receive a "Race to the Top -- Early Learning Challenge Grant" (RTT-ELCG). Massachusetts' successful application was largely the result of collaboration across state agencies, with significant MDPH involvement, and also with community leaders to develop a comprehensive, aggressive plan for a well-coordinated system of education and care for young children. Core to this plan is strategic and intentional collaboration across state family and child-serving systems, reflecting the shared responsibility of childcare, health, housing, education, child welfare, mental health, and economic development to improve outcomes for children. A retreat to engage state leadership and initiate planning and a decision-making process for action has already taken place, with delegations from 16 state agencies and the legislature attending.

During the past year MDPH staff have also been instrumental in the creation of the Young Children's subcommittee of the Children's Readiness Cabinet, led by Early Education and Care Commissioner Sherri Killins. The goal of this body is to affirm and support cross agency initiatives and on-going development of comprehensive systems of care for young children and to assure they arrive at public school healthy, prepared and ready to learn.

The Massachusetts Department of Housing and Community Development, the City of Boston and the Massachusetts Department of Public Health (MDPH) have begun working together on the Leading the Way Home (LTWH) program, a city-state collaboration that is offering Housing Choice Voucher Program (Section 8) housing assistance and ongoing support services to 500 families in Emergency Assistance shelters. This project is being supported by the Boston Interagency Council on Housing and Homelessness Network and the Boston Housing Authority (BHA). //2013//

In the specific area of CYSHCN, Title V collaborates with a number of other state and federally funded agencies and organizations to address the needs of individuals with developmental disabilities. The Director of Family Initiatives (DFI) represents the Department as a council member on the Massachusetts Developmental Disability Council (MDDC). As a Council member, she provides information about MDPH resources, reviews grants and assists families to access Consumer Empowerment Funds. In addition, the Director of Family Initiatives sits on the Advisory Board of the Institute for Community Inclusion (ICI), one of Massachusetts' two University Centers for Excellence in Developmental Disabilities. ICI works across the lifespan to develop and disseminate both programs and resources. The DFI provides the public health and the family perspectives on the need for and availability and efficacy of these programs, resources and community based supports for individuals with developmental disabilities. The DFI works with both Massachusetts LEND programs to identify opportunities for collaboration and resource sharing. She participates on an interagency working group of liaisons from all EOHHS agencies working to make state and federally-funded supports for families of CYSHCN more flexible and

family directed.

/2012/The Title V agency was selected in the Spring of 2010 as the lead agency for the ACA-funded evidence-based Maternal, Infant, and Early Childhood Home Visiting Program. In an effort to broaden input into recommendations for the program's design and implementation, a cross-agency collaborative Task Force was established. This body has been co-chaired by the Commissioner of the Department of Early Education and Care and the MDPH Medical Director. Additional membership includes representatives from the Executive Office of Education, Department of Transitional Assistance, the State's Medicaid Program, and the Children's Trust Fund (as the CAPTA Title II agency and funding agency for the state's current evidence-based home visiting programs, Healthy Families Massachusetts.) //2012//

/2013/ MDPH continues to work collaboratively at the secretariat level with EOHHS and EOE; at the state level with the Children's Trust Fund (CTF), the Department of Children and Families (DCF), the Department of Transitional Assistance (DTA), the Department of Early Education and Care (EEC), and MassHealth (state Medicaid agency) to further develop and implement the MHVI. In addition, MDPH is coordinating with multiple evaluators including Tufts University, the Donahue Institute and Harvard-Catalyst to evaluate program effectiveness at the individual, family, community, and state levels. Finally, MDPH has established multiple venues for input from community stakeholders including agencies providing services and the families they serve.

BFHN also continues to work collaboratively with other MCHB grantees in Massachusetts and the region. The Bureau Director and staff speak to each new group of LEND Fellows at both the UMASS/Shriver Center and Children's Hospital/ICI UCEDD Programs. Opportunities for collaborative projects are developed annually with LEND Fellows.

The Director of Family Initiatives sits on the Advisory Boards of the two Massachusetts LEND programs and the Harvard School of Public Health Maternal and Child Concentration Program. The DFI is a member of a newly formed regional group, the New England Continuing Education Collaborative, established by the Directors of the MCH concentration at HSPH and BUSPH, which provides guidance on the development of training and education for the MCH and Public Health work force.

In FY 12, two projects were carried out with MCH concentrators at HSPH. Students assisted in the development of an evaluation for the MDPH Care Coordination program and the development of a family friendly guide to web-based health information. //2013//

/2013/ Several other current collaborations with state and community partners include the following:

Partnership to Eliminate Disparities in Infant Mortality -- Action Learning Collaborative (PEDIM-ALC): MDPH, in collaboration with the Boston Public Health Commission, is currently an active participant and co-lead of the PEDIM-ALC which is applying the life-course theory to the issue of the impact of racism on health disparities including infant mortality. The PEDIM-ALC is jointly supported by City MatCH and AMCHP.

Perinatal Quality Collaborative: MDPH is collaborating with the March of Dimes to support the Massachusetts Perinatal Quality Collaborative. The goal of MPQC is to improve the perinatal outcomes of Massachusetts residents by quickly identifying and facilitating the adoption of proven, cost effective, evidence based practices at the state's maternity facilities.

Healthy Homes Project: The BFHN is collaborating with the Bureau of Environmental Health (BEH) to ensure that home-based programs within BFHN maintain a focus on the principles of the Healthy Homes Project. The Massachusetts Healthy Homes is a

partnership of public and private partners promoting healthy homes in healthy communities by securing resources, designing integrated systems for action, providing education, and fostering cost-effective, prevention-oriented, and sustainable policies and practices. The goal of the project is to support optimal health by preventing indoor environmental health risks and to ensure that all homes are safe, dry, clean, pest-and contaminant free, affordable, accessible, energy efficient and well maintained. Although federal CDC funding for the Healthy Homes initiatives has been eliminated, the Commonwealth is continuing to apply the model as much as possible.

Critical Congenital Heart Disease (CCHD) Screening Advisory Work Group: In FY12, the Department established the Critical Congenital Heart Disease (CCHD) Screening Advisory Work Group to advise the department on the recommendation to add pulse oximetry screening for the detection of CCHD to the newborn uniform screening panel. This recommendation was recently endorsed by the Secretary of Health and Human Services and the Academy of Pediatrics. Through this CCHD work group, MDPH is seeking input and advice on the impact of pulse oximetry screening on hospitals, clinicians and families; and processes and protocols for incorporating CCHD screening in hospital settings that maximize the best outcomes for newborns and minimize burden and disruption on facilities, clinicians and families. The group is chaired by the MDPH Medical Director, Dr. Lauren Smith, and includes pediatric cardiologists, neonatologists, and representatives from organizations such as the American Heart Association as well as MDPH program staff from newborn metabolic screening, newborn hearing screening and birth defects. This is a time-limited advisory group. Two meetings have already taken place; they included presentation and discussion of CCHDs in MA, pilot CCHD screening at U Mass Medical Center, results of a survey of all MA maternity hospitals and assessment of MA pediatric cardiologists. Two more meetings are planned for the fall. The first will center on approaches to CCHD screening used in other states as well as screening implementation and costs issues; the final meeting will focus on recommendations to the Commissioner. We expect the Committee's work to be completed by the end of October 2012.

We have also submitted a proposal to CDC titled "Surveillance of Congenital Heart Defects Focusing on Adolescents and Adults in Massachusetts". MDPH has proposed leading a collaborative effort to conduct surveillance of diagnosed congenital heart defects (CHDs) among adolescents and adults in Massachusetts (MA), as well as assess health care utilization, morbidity and mortality in this group of individuals. We also will focus on pregnant women as a population with distinct needs. Our team includes clinical experts at Children's Hospital and MGH who oversee the largest cardiac specialty clinical programs in the state that serve adolescents and adults with CHDs. The group includes the largest and longest-running hospital-based birth defects surveillance systems in the country, the Brigham and Women's Hospital Active Malformation Surveillance Program or BWH AMSP, as well as two MA health quality partnerships: an overall health quality group and a group specifically focused on pregnant women.

Massachusetts was recently selected as one of seven states to participate in AMCHP's collaborative Life Course Metrics Project. This project has convened a National Expert Panel as well as state teams to establish a framework and guiding principles for identifying a core set of indicators ("metrics") that can be used to measure progress using the life course approach to improve maternal and child health. Our team will include the MCH Director, the state MCH epidemiologist, the Director of Family Initiatives, Boston community partners with extensive knowledge of life course, and colleagues from Boston University. //2013//

An attachment is included in this section. III E - State Agency Coordination

F. Health Systems Capacity Indicators

Introduction

The Health Systems Capacity Indicators are actively used by Massachusetts to track the health of the Commonwealth and to inform public health policy and practice. These indicators are part of a much larger set of indicators that are routinely reviewed and that help shape efforts to reduce health disparities and target both programs and other systems capacity resources appropriately. Analyses by race, ethnicity, age, and other characteristics -- at both the state and local level -- are key components of our approach. A particular emphasis is working with communities at greatest risk to develop their own capacity to use data to create, implement, and monitor strategic plans. These indicators are also among the risk indicators used for tracking and early identification and for needs assessments for procuring community-based services. Massachusetts has been a leader in the development of programs based on data analysis and on the development of innovative systems of care. We have dedicated epidemiology resources and provide leadership using surveillance data, expanding data utilization and applying data to public health policy. Our systems capacity is excellent in the areas of health care resources, Medicaid and other public benefits, and a national model universal health insurance system. We have a number of strong data system linkages that promote improvements in systems capacity, some of them unique (e.g. PELL).

Among our challenges is to better understand how systems capacity problems contribute to persistent health disparities and reconciling various or conflicting federal, state, and program-specific data sharing rules. The discussion below addresses HSCIs 1, 2, 4, 5A-D, 7B, and 9A-B.

HSCI 01: The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.

Asthma is a significant public health challenge in Massachusetts and an area where we continue to explore methods to collect and analyze data more effectively. The hospital discharge database remains in continuous change and improvement, with Observation Discharges and Emergency Room visits being added in recent years, but not for every data year. The multiple possibilities for capturing ICD codes at various levels (primary diagnosis, secondary, etc.) make these data more challenging to interpret over time than vital statistics. Our Asthma Planning grant is helping promote closer analyses. In addition, changes in medical care practice (and hospital/insurance policies) may create changes in where similar cases are recorded from year to year, making trend analysis complex.

The Asthma Prevention and Control Program works to improve the quality of life for all Massachusetts residents with asthma and to reduce disparities in asthma outcomes. Funded by CDC grants to address asthma from a public health perspective, and implemented in close collaboration with the broad-based Massachusetts Asthma Advocacy Partnership, the Program's activities include: expanding asthma surveillance, broadening statewide and regional asthma partnerships for coordinating action on asthma, and improving asthma management and control. Included in the Program's activities are efforts to reduce exposure to asthma triggers and irritants in homes, licensed childcare centers, schools, workplaces and senior centers. Another Program focus is researching effective interventions to reduce asthma disparities. Through its Asthma Disparities Initiative, the Program supports pilot projects in the regions most affected by asthma both to improve clinical care and to develop and coordinate asthma coalitions. The Program provides Asthma Action Plans for children and adults in seven languages. Among the program's data-driven activities has been release of an asthma burden document with comprehensive data about asthma in Massachusetts in April 2009 and a 5-year Strategic Plan for Asthma 2009 - 2014 that includes specific action steps to improve asthma for young children.

Complicating factors for this measure include: (1) asthma prevalence in Massachusetts continues to increase every year resulting in more children needing asthma intervention services; and (2) asthma in children aged 0 - 2 is often undiagnosed. Asthma in very young children often first presents at the hospital. Physicians are hesitant to diagnose asthma before 2 years of age due to the developing respiratory system. Still, improving this measure is an important goal for MDPH as

children ages 0 - 4 have the highest rate of hospitalization in the state for any age group.

In 2013, APCP will update its Asthma Burden Document that summarizes asthma morbidity and mortality for Massachusetts using all 12 data sets available in Massachusetts. It will release this document in the summer or fall of 2013. In addition, if time allows APCP will disseminate local asthma fact sheets that include small area estimates from the BRFSS of adult asthma prevalence, along with other measures currently available for local application.

The Bureau of Environmental Health (BEH) has implemented a surveillance system to capture asthma prevalence in the 5-14 year old age group. This surveillance system, started in 2002 has helped to document the prevalence of pediatric asthma in Massachusetts. The next report (for the 2008 - 2009 school year) is pending publication. The School Health Unit collaborates with the BEH on annual asthma surveillance based on information reported to school nurses.

The importance of this health systems capacity indicator -- and the data showing the Commonwealth has much room for improvement in this critical measure of health disparities -- has resulted in a targeted variant of it being selected as one of our State Performance Measures, based on our 5-Year Needs Assessment and identification of priority need areas: the hospitalization rate per 100,000 among Black, non-Hispanic and Hispanic children ages 0 - 4. Additional information about activities in support of this SPM can be found in the Narrative for SPM #7.

HSCI 02: The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

Based on Medicaid EPSDT data, all enrolled infants are receiving some periodic screening. However, data on the consistency and quality of the screening, and the thoroughness of referrals, follow-up, and treatment are not readily available. A number of our programs (e.g. MCH home visiting programs, Early Intervention, and WIC) work to assure that all infants, including those on Medicaid, receive comprehensive screening, assessment, and referrals. This focus has expanded as we continue to address unmet needs related to pediatric health and medical home initiatives for all children. Title V meets with MassHealth personnel and continues to discuss periodic screening and EPSDT data timeliness and quality across the age span.

The EOHHS Children's Behavior Health Initiative (CBHI) has been established to implement the court order in the Rosie D. lawsuit that requires universal behavioral screening at each EPSDT visit. CBHI requires Managed Care Organizations and primary care providers under contract to MassHealth to offer to screen MassHealth-enrolled children and youth aged <21 years (including infants) with one of eight MassHealth-approved standardized behavioral health screening instruments during preventive care Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and Preventive Pediatric Healthcare Screening and Diagnosis (PPHSD) visits. CBHI reports on BH screenings quarterly and has identified a lower percentage of screens for infants B-6 mos. and for transition aged youth. The MCH Director and Asst. Director of EC Services are part of a committee that reviews the menu of tools annually, and is exploring tools that would be a better match for these two age groups. The Title V Director is a member of the CBHI Implementation Coordinating team. Additional components of CBHI include the development of an information-technology system to track assessments, treatment planning, and treatment delivery; and a requirement to seek federal approval to cover several new or improved community-based services. MassHealth continues to pursue quality improvement initiatives to increase member and provider awareness of, and provider compliance with, the screening requirement.

HSCI 04: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

This indicator is affected by women entering prenatal care after the first trimester. Late entry into care ultimately results in inadequate care scores. MA PRAMS 2010 data show that about 8.2% of women (compared to 12% in 2009) reported not receiving prenatal care as soon as they had wanted. Compared to the 2009 data, late entry to PNC in 2010 also decreased among Black non-Hispanic (14.1% vs. 17.3%), Hispanic (9.3% vs. 13.7%), and white non-Hispanic (6.6% vs. 11.2%); however, these differences are not statistically significant. As in previous surveys, the reasons given were often related to the health care system. This supports anecdotal evidence that some physicians counsel women not to come in for prenatal visits until after the 12th week, particularly if the woman has had a prior birth with good outcomes.

See also NPM # 18 and SPM # 09 for additional information about numerous activities related to the improvement of this HSCI. A number of activities and data analyses are underway, including PRAMS and PELL, as we continue to seek improvements in prenatal care. A few key items are listed below:

Prenatal enrollment in WIC in the 1st trimester has been incorporated as an outcome measure into WIC's Performance Management System. All local programs establish individual goals for improvement in early prenatal enrollment as part of a larger system of performance management focused on improved health outcomes and quality services.

On-going analyses may provide guidance on what actions would be most effective in changing physician and health care provider behavior to assure more prompt appointment scheduling -- especially for women at the highest potential risk of poor birth outcomes.

HSCI 05A - D: Medicaid / non-Medicaid comparisons of LBW, IMR, Early prenatal care, and adequate PNC

Low birthweight infants (LBW, weighing less than 2,500 grams) are at increased risk of morbidity and mortality compared with infants of normal weight and are at higher risk of delayed development and poor school achievement later in life. MDPH uses this HSCI to monitor the prevalence of LBW infants by insurance type and to track progress toward achieving the Healthy People 2020 goal of 7.8% LBW births. The percentage of LBW infants in MA in 2010 was 7.76%, with 8.2% among the Medicaid population and 7.6% among non-Medicaid women. Massachusetts achieved the Healthy People 2020 goal of 7.8% LBW birth in 2008.

Maternal risk factors such as smoking, substance use, poor nutrition, low income, lack of education and inadequate prenatal care are associated with LBW; these risk factors are often overrepresented in Medicaid populations. With the full implementation of PRAMS (starting with 2007 births) and ongoing linkages in the population-based Pregnancy to Early Life Longitudinal Data System we have steady access to information on perinatal risk factors associated with adverse birth outcomes including LBW. Findings from such analyses can be used to inform efforts to develop effective, targeted interventions for the prevention of prematurity and low birthweight, both at the state level and in concert with local areas at particular risk.

The Perinatal Data Committee uses the PELL data systems to analyze specific maternal and infant outcomes including transfers between birth hospitals to assess the impact of the revised maternal and newborn hospital licensure regulations on whether women are giving birth at a hospital level appropriate for maternal and newborn care needs. The committee is using baseline birth data gathered prior to the promulgation of the regulations.

Perinatal Periods of Risk (PPOR) analyses are being used for both the state and the city of Springfield as part of the Perinatal Disparity Project activities. Community packets related to teen birth and infant death are disseminated to communities with highest infant mortality and teen birth rates each year. At the state level, excess fetio-infant mortality rates have remained relatively stable over the last 5 years, although the disparity gap between black and white has decreased from previous analyses. In 2005-2009, the excess fetio-infant mortality rate among black mothers

was 5 times higher than that of white mothers (compared to 6 times in 2004-2008).

In FY10, the MDPH Medical Director convened a group of DPH staff from Family Health and Nutrition, Substance Abuse, Community Health Access and Promotion, and the Health Information, Statistics, Research and Evaluation to establish a process for reviewing infant deaths statewide, the Review of Infant Mortality (RIM). The purpose of the RIM is to decrease the incidence of preventable infant deaths in Massachusetts. The RIM guiding principles include using an understanding of the causes of and contributors to infant mortality to inform policy and program priorities; complementing work done within the Birth Defects Program and by the Child Fatality Review Program; reviewing infant deaths within the frameworks of the life course perspective and social determinants of health; identifying and addressing disparities; ensuring that review teams are multidisciplinary; and partnering with communities to implement recommended action steps to reduce infant mortality and eliminate disparities in infant mortality. Initially, RIM will include infants under one year who death was caused by prematurity (< 37 weeks) or a known medical cause. Fetal deaths and infant deaths due to injury, violence and sudden unexplained infant death (SUID) will be excluded. The review process will include both surveillance of all infant deaths meeting criteria for RIM inclusion and an in-depth review of a sub-sample of infant deaths. Based on these reviews, the RIM will develop and disseminate recommendations for preventing infant deaths, and will work with local communities to implement and evaluate recommended strategies to prevent infant deaths.

In FY11, RIM reached out to partners at the statewide child fatality meeting, local DA offices, and local fetal infant mortality review sites to explain its purpose and strategy. Currently, RIM is developing internal and external agreements to access pertinent data and records related to infant death. To support this review process, RIM developed a database to have a timely feed of both infant birth and death records.

Entry to prenatal care (PNC) in the first trimester of pregnancy is recommended because of its potential to improve the health of both mothers and infants. The Healthy People 2020 target is that at least 77.9% of women receive PNC before the end of the first trimester of pregnancy. MDPH uses this HSCI to monitor trends in the timing of initiation into prenatal care and to monitor our progress toward achieving the HP2020 goal. Just under 83% of Massachusetts mothers giving birth in 2010 initiated prenatal care in the first trimester of pregnancy (76% among Medicaid mothers and 85% among non-Medicaid mothers). These rates had been well under the HP2010 goal (or 90%), but Massachusetts has now exceeded the 2020 target except for Medicaid mothers.

Maternal risk factors such as substance use, domestic violence, and depression can affect both prenatal care utilization and perinatal outcomes; these risk factors are often overrepresented in Medicaid populations. Our increasing capacity to analyze perinatal risk factors and outcomes in a comprehensive and timely manner through such mechanisms as PELL and PRAMS will add to our ability to develop effective, targeted interventions, both statewide and community-based, to increase early entry to prenatal care, particularly for Medicaid women.

PRAMS data provide useful information about prenatal care utilization including timing of entry into prenatal care, whether the woman was able to get prenatal care as early as she wanted, and barriers to receipt of prenatal care. In 2010 (the most recent PRAMS data available), 92.7% of MA mothers initiated prenatal care in the first trimester; however, mothers on Medicaid were less likely to (87.8%) than non-Medicaid mothers (95.5%). More than 82% of mothers received prenatal care deemed adequate or adequate plus as measured by the Kotelchuck Index. Medicaid women were more likely to receive inadequate or no prenatal care (13.3%) compared with women who had non-Medicaid insurance (6.5%). Women who were white, non-Hispanic (95.2%), aged 30-39 years (95.5%), aged 40 years or above (95.3%), some college (91.6%), college-educated (96.8%), and had non-Medicaid insurance (95.5%) were the groups to reach the HP2010 target for early initiation of prenatal care. Leading causes for not receiving prenatal care as early as was wanted among those reporting not receiving prenatal care as soon as they

wanted were (not mutually exclusive): didn't know about pregnancy (44.6%), inability to get an appointment (38.8%), doctor or health plan would not start care as early as the mother wanted (19.8%), too many other things going on (16%), couldn't afford it (11.6%), didn't want anyone else to know about the pregnancy (10.3%), couldn't take time off from work or school (9.4%), didn't have a Medicaid card (7%), and no transportation (6.2%).

Women who were white, non-Hispanic, Asian, Other race, aged 30 years or above, some college, college-educated, and had non-Medicaid insurance were the groups to reach the HP2010 target for early initiation of prenatal care in Massachusetts.

Adequacy of prenatal care utilization (APNCU) Index describes several aspects of prenatal care, including the timing of entry to care and the volume of care received. Prenatal care classified as "Adequate" started early in the pregnancy and involved the expected number of prenatal care visits given the duration of the pregnancy. Less than adequate care generally involves late entry and/or insufficient number of visits.

Of the 72,836 Massachusetts resident births in 2010, 65,796 (90.3%) received the observed to expected prenatal visits, a marked improvement from the 2008 rate of 80.2%. Among Medicaid recipients 88% versus 91% among non-Medicaid received the observed to expected prenatal visits; the improvement was seen in both groups. In 2010, Medicaid women were more likely to receive inadequate or no prenatal care (10.4%) compared with women who had non-Medicaid insurance (7.1%)

Late entry into care usually results in inadequate care scores. PRAMS data are also used for further analysis of demographics and reasons for late entry to care. PRAMS 2010 data show that 8.2% of women reported not receiving prenatal care as soon as they had wanted, improved from 12% in 2009. Among those not receiving care as early as desired, reasons related to the health care system were most often cited. Not being able to get an appointment sooner was the second most common reason for not receiving timely care (38.8%) and doctor or health plan would not start care as early as the mother wanted (19.8%) was the third most common cause of delay. PRAMS data were also used for further analysis of demographics and reasons for late entry to care. While MA mothers demonstrated high levels of timely prenatal care utilization (92.7% overall) in 2010, substantial differences were evident across socio-demographic groups. Beginning care in the first trimester was lowest among non-Hispanic black mothers (85.6%), less than 20 years old (89.1%), less than high school educated (85.5%), and those living below or at 100% federal poverty level (84.5%). Those for whom Medicaid was a source of prenatal care payment were also less likely to enter care in the first trimester (87.8%). All of these subgroups except those living below or at 100% federal poverty level, however, showed improvement in the 2010 survey results.

HSCI 07B: The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

MassHealth benefits include dental care for children. Utilization rates have increased due to number of positive changes: improved payment rates, increased recruitment of dentists, increased pediatric dental services available at community health centers, and increased promotion of the importance of dental care through a number of initiatives. An on-going issue for children on MassHealth is availability given the number of dentists who accept MassHealth and the uneven geographic distribution of dentists across the state.

We work closely with Medicaid, dental professionals, schools, community-based health care providers, and advocates in a variety of ways to improve oral health services and preventive oral health measures (including fluoridation) for all children. Efforts include direct care and enabling services, population-based activities, and a great deal of infrastructure and capacity building. These efforts have been enhanced through competitively awarded HRSA/MCHB grants targeted at oral health workforce development and at improved systems for oral healthcare access for

children.

The Office of Oral Health (OOH) has worked with MassHealth to develop a statewide oral health prevention plan to increase the number of underserved and unserved children receiving preventive services in school settings and is collaborating with interested dental and health professionals in developing school-based oral health programs (education, screenings, sealants and fluoride) and increasing the number of MassHealth children served in them. In FY10, the OOH began implementing statewide expansion of school-based oral health prevention (sealant) programs statewide focusing on schools with greater than 50% free and reduced school lunch participation and in communities with greater than 10,000 MassHealth children.

OOH is also working with Mass Health and the MCAAP to implement the recommendation of each child having an oral health assessment at 1 year. MassHealth now reimburses pediatric health providers to apply fluoride varnish during well-child visits. OOH developed a tool kit and is conducting trainings of medical providers focusing on community health centers.

State legislation has created a public health dental hygienist category to work without the supervision of a dentist. Dental hygienists can now bill MassHealth directly, increasing the number of low income children receiving sealants and fluoride. In school year 2011-2012, the Department's school-based oral health program is providing services in 120 high-need schools, 12 with school-based health centers, in 9 communities statewide./

Health Systems Capacity Indicator 09A and B: The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.

These Health Systems Capacity Indicators reflect the breadth and scope of the Commonwealth's historic commitment to MCH data capacity. We have highly skilled internal staff and systems, including a number of MCH epidemiologists and an Office of Data Translation (ODT) that enable us to carry out most of these capacity items. Over time, the number of areas where the Title V staff have direct access to or manage these data systems has increased. This HSCI (along with HSCI #09B) serves as the performance measure for our state SSDI grant. More detailed information about these and other data capacity and data translation activities can be found in the attachment to Part IVF in the discussion of Massachusetts Priority #10 (Improve data availability, access and analytic capacity).

Massachusetts PRAMS continues its data collection and reporting activities. PRAMS updated its surveillance report in 2012. PRAMS data are now available for CYs 2007 -- 2010. SSDI continues to support PRAMS by funding an MCH epidemiologist who serves part-time as the PRAMS Project Director.

A second key SSDI project is to continue WIC data linkage to births using the PELL data system. WIC data are now available for linkage in a timely manner. Establishing linkages to WIC included a contract that formally provides funding from WIC to PELL and gives the programmers status as WIC consultants, easing access concerns.

Our only incomplete score is for direct linkages between birth files and Medicaid. Linkage of births with Medicaid (including SCHIP, Healthy Start, and other programs); higher scores are not expected soon. Given federal regulations, MassHealth may share identifiable data only to support MassHealth purposes; this has proven difficult to accomplish. MassHealth has expressed interest in PELL longitudinally linked data concerning interpregnancy intervals. Specifications for a new MassHealth information system include linkage with births as part of eligibility determination, and Title V is represented in systems planning.

With PRAMS now fully operational, 2010 PRAMS data were used to measure third trimester smoking (NPM 15) and first-trimester prenatal care and to develop a number of topic-specific fact sheets. PRAMS data have been linked with PELL and analyses are ongoing.

Data on youth smoking are available from both the Massachusetts Youth Risk Behavior Survey (MYRBS) and the Massachusetts Youth Health Survey (MYHS). These two surveys were combined in FY07 and are administered in odd-numbered years on a bi-annual basis. We have full access to the data from the new survey methodology. The consolidation resulted in a more efficient use of limited resources, more consistent data, and better continued cooperation from school districts in allowing the surveys to be administered regularly.

Statewide surveillance data as well as local program data on youth smoking are actively used to guide and evaluate the programs and initiatives of the Massachusetts Tobacco Control Program. Findings show that state funded initiatives have reduced teen smoking and limited minors' access to tobacco products.

Youth surveillance data are also used to identify health disparities and to guide the development of programs and targeting of resources in multiple areas in addition to tobacco use. These areas include suicide prevention, substance use, healthy weight and physical activity, violence, and other risk behaviors.

Data from the recently released 2011 joint administration of the MYHS and MYRBS in collaboration with the MA Department of Elementary and Secondary Education will provide updated estimates of the prevalence of health conditions, risk and protective factors and help identify areas of concern and opportunities to improve outcomes.

See the narrative sections of NPMs # 1, 8, 12, and 15 and SPMs for additional information on how data systems are used. Also see the discussion in the Attachment to Part IV, Section F for Priority Need #10 related to the integration of systems and data and the use of data to inform practice.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The "Title V Block Grant Performance Management System," established under the Government Performance and Results Act (GPRA -- Public Law 103-62) is designed to document the State's progress on measurable performance targets and outcomes. Specific program activities are to be described and categorized by the four service levels found in the MCH "pyramid" -- direct health care, enabling, population-based, and infrastructure building services -- in a flexible manner to best address the priority needs of the state in the context of its capacity. Program activities, as measured by 18 National performance measures and from 7 to 10 State performance measures should have a collective contributory effect to positively impact a set of 6 National outcome measures for the Title V population.

Accountability is determined in 3 ways: (1) by measuring the progress towards successful achievement of each individual performance measure; (2) by having budgeted and expended dollars spread over all four of the recognized MCH services (direct health care, enabling services, population-based services, and infrastructure building services); and (3) by having a positive impact on the outcome measures. While improvement in outcome measures is the long term goal, more immediate success will be realized by positive impact on the performance measures which are shorter term, intermediate, and precursors for the outcome measures. This is particularly important since there are other significant factors outside of Title V control affecting the outcomes and the outcomes may not reflect all of a state's long-term goals. [For example, all 6 of the National Outcomes are variations on mortality rates and they do not include measures of lifelong wellbeing, educational attainment, productivity, etc.]

The chart attached to this section summarizes for Massachusetts the relationships among the Needs Assessment, the new Priority Needs, the MCH "Pyramid," National Performance and Outcome Measures, the 10 new State Performance Measures (SPMs), and the one new State Outcome Measure. As required, the new Priority Needs and Performance Measures collectively address all MCH populations and levels of the MCH Pyramid. In fact, many of the Priority Needs and SPMs address issues that relate to all MCH populations and/or involve proposed actions at more than one level of the pyramid. Partnership funds are budgeted for all populations and across all levels of the Pyramid. **/2013/ [Note that subsequently we have deactivated SPM # 3.] //2013//**

In terms of measuring our success at improving maternal and child health through the Federal-State MCH

Partnership, the overall health status and access to health care services of the MCH population in Massachusetts continues to improve. At the same time, there are some areas in which this generally positive progress has reached a plateau, or in which poorer outcomes have persisted. Even where there have been improvements overall, significant disparities in outcomes and measures persist for some population groups or areas of the Commonwealth. Because of wide and growing coverage of health services through MassHealth and Health Care Reform, relatively little Title V funding is expended on direct medical services. Rather, BFHN efforts are primarily focused on non-medical direct services, enabling, infrastructure and population-based services to further improve accessibility and coordination of services. In particular, data analysis and the development of innovative linked datasets continue to be strengths of the Massachusetts program. They are critical to our better understanding of the underlying contributing factors to poor health outcomes or disparities in order to develop and target strategies for improvement.

Status of Progress on Measures for FY09 Annual Report

To more specifically address progress, the status of FY09 Annual Performance Objectives for Massachusetts is summarized below:

National Performance Measures (18 in total)

8 Annual Performance Objectives Met or Exceeded (#01, 07, 08, 10, 11, 12, 14, and 16)

5 Annual Performance Objectives -- No new data for FY09 (# 02, 03, 04, 05, 06).

5 Annual Performance Objectives Not Met (#09, 13, 15, 17, and 18).

Current State Negotiated Measures (9 total):

5 Annual Performance Objectives Met or Exceeded (#02, 06, 09, 10, and 11)

2 Annual Performance Objectives -- No new data (#01 and 08)

2 Annual Performance Objectives Not Met (#03, and 04).

/2012/Status of Progress on Measures for FY10 Annual Report:

National Performance Measures (18 in total)

5 Objectives Met or Exceeded (#01, 08, 11, 12, and 13)

7 Objectives -- No new data (# 02, 03, 04, 05, 06, 10, and 16)

6 Objectives Not Met (#07, 09, 14, 15, 17, and 18).

Current State Negotiated Measures (9 total):

2 Objective Met or Exceeded (#01 and 02)

1 Objective -- No new data (#10)

6 Objectives -- Not applicable (#04, 05, 06, 07, 08, and 09). These Objectives were newly defined last year.

Baselines and targets are being established with this application. //2012//

/2013/Status of Progress on Measures for FY11 Annual Report:

National Performance Measures (18 in total)

12 Objectives Met or Exceeded (#01, 07, 08, 09, 10, 11, 12, 13, 14, 15, 17, and 18)

2 Objectives indeterminate (#02 and 05) -- It appears that we improved well above our projected score on NPM #02 and did not meet our projections for NPM #05. However, neither of these measures, as captured in the most recent NCYSHCN survey is comparable to the corresponding question in the previous survey, so we don't know how we would have scored against the same questions from the earlier survey.

4 Objectives Not Met (#03, 04, 06, and 16). For the first three measures, scored from the NCYSHCN survey, our interim projections from the last 2005-2006 baseline proved to be too optimistic. We have reset what we hope are more realistic targets from these new benchmark scores. For #16 (youth suicides), we are closely analyzing the recently released 2010 death data, which show a sharp increase in this rate.

**Current State Negotiated Measures (9 total):
5 Objectives Met or Exceeded (#02, 04, 06, 08, and 10)**

1 Objective -- No new data (#01). SPM #01 is measured through biennial survey data last gathered in FY10 which will be repeated in FY12.

3 Objectives Not Met (#05, 07, and 09). Benchmarks and projections for all of these measures were just set last year; they are being adjusted for future years based on these additional data findings and trends. //2013//

On the National Outcome Measures, Massachusetts continues to have outcomes that are generally better than the national average, but improvement against our own benchmarks for the 5 perinatal and infant mortality measures remains a priority. A number of new initiatives have been started to identify what factors can be changed or influenced to reduce perinatal mortality. **//2013/ In 2010 (the most recent data available), we exceeded our targets for 5 of the 6 national outcome measures.//2013//**

An attachment is included in this section. IVA - Background and Overview

B. State Priorities

From its analysis of the Needs Assessment findings, Massachusetts selected the following 10 Priority Needs. These priorities are equal in importance and are not listed in any "ranked" order. The chart attached to the previous section (Part IV, Section A) summarizes the relationships among the Needs Assessment, new Priority Needs, the MCH "Pyramid," National Performance and Outcome Measures, and the 10 new State Performance Measures (SPMs).

The performance measures related to each priority are referenced below by priority. The relationships between the Massachusetts State Priorities and both NPMs and SPMs are displayed visually in the table, which is the first page of the Attachment to this section.

Two of the new State Performance Measures are composite measures, scored by unique scales. The Checklists for each of those SPMs are also attached to this section, following the Table.

Please note that additional information on activities that address Priority Needs not covered by

NPMs or SPMs is provided in the annual Attachment to Part IV, Section F. For 2011, this attachment includes information on our Current Priority Needs # 1, 2, 4, 6, 7, 8, 9, and 10. //2012/ For 2012, the attachment includes information on our new Priority Needs # 1, 2, 3, 4, 5, 6, 7, and 10. //2012//

//2013/ For 2013, the attachment includes information on our new Priority Needs # 2, 3, 4, 5, 6, 7, 9, and 10. //2013//

Priority Need #1: Promote Healthy Weight

Healthy weight is emerging as a critical public health issue over the next decade. The rationale for addressing healthy weight as a Priority Need is clear and MDPH has the access to resources and the position in the community to be a key voice on healthy weight. The Needs Assessment presents many statistics addressing the scope and severity of issues related to healthy weight, including health disparities. The majority of Massachusetts residents are obese or overweight and 30% of children/youth are overweight. Obesity is associated with multiple adverse short- and long-term health outcomes particularly with overweight starting early in life (diabetes, gestational diabetes, heart disease, etc.), which disproportionately affect minorities. Action on this MCH priority is feasible, has strong political will and is aligned with several MDPH initiatives (Mass in Motion, Wellness Promotion Advisory Board). There is an opportunity to leverage programs touching many populations (WIC, EI, Essential School Health Services) and community resources.

Over the next year, this Priority will be measured through a developmental SPM. (SPM6: Develop an MCH healthy weight measure that aligns with MDPH's overall strategy for promoting healthy weight across all populations). A strategic planning process with further stakeholder input and engagement will more clearly define the healthy weight strategy before creating a specific process or outcome measure. Other related measures include NPM14 (WIC BMI) and NPM11 (Breastfeeding). ***//2013/ On July 1, 2012, Massachusetts became the second state in the country, after Rhode Island, to eliminate formula marketing in birth hospitals. There are now three hospitals and one birth center in the state that have received a Baby Friendly designation and many others are moving towards becoming baby friendly.//2013//***

Priority Need #2: Promote emotional wellness and social connectedness across the lifespan
Emotional wellness is a broad need affecting the development of individuals, especially children, at key times in their lives. Indicators include depression, feeling sad and hopeless, violence, bullying, suicidality, and other behavioral health problems. During interviews, internal and external stakeholders consistently highlighted the need for mental health support, lack of capacity and service gaps for all MCH populations. Solutions involving collaboration among state agencies, providers, families, and other policymakers can include universal screening and risk identification, broad-based education and communication, improved training and workforce development, improved treatment services and reimbursement, and better data. Current efforts such as the Children's Behavioral Health Initiative will continue to support progress.

This Priority will be measured through a combination of NPM16 (Adolescent suicide deaths) and a state developed process measure SPM2. With technical assistance from MCHB, an MCH measure for emotional wellness and social connectedness across the lifespan and at the individual and systems levels will be developed by July 2011. SPM2 will identify steps and success indicators to improve the state's understanding and focus on mental health issues. ***//2013/ The state developed process measure has been finalized and is being implemented. //2013//***

Priority #3: Coordinate preventive oral health measures and promote universal access to affordable dental care

In Massachusetts, the lack of dental care is highly correlated with income. Improving prevention and access to oral health care are critical needs for children and youth, and for low-income adults. Blacks and Hispanics in Massachusetts have much higher rates of tooth loss compared to

Whites. Decay and caries correlate with poor adult dental health and the prevalence of dental caries is nearly twice as high in non-White kindergarten children as in White children. Seventeen percent of the state's 3rd graders have untreated decay. Changes in Medicaid rules and payment schedules have improved access over the last 5 years, as have initiatives promoting fluoride varnish, childcare/Head Start programs, school programs, and guidelines/standards for portable oral health programs, including expanded public health roles for dental hygienists. But there is still much room for improvement.

This Priority will be measured through NPM16 (Dental Sealants) and a new SPM4 (The percentage of women with a recent live birth reporting that they had their teeth cleaned recently (within 1 year before, during, or after pregnancy)). Providers rarely mention the importance of oral health during prenatal visits, thus missing a key opportunity to decrease gaps in oral health care. SPM4 will help measure success of efforts in this area. ***/2013/ In 2013 we will continue the exciting new activities begun in FY12 to advance perinatal oral health; see SPM # 4 for more details.//2013//***

Priority Need #4: Enhance screening for and prevention of violence and bullying
The adverse physical and mental health outcomes associated with exposure to violence, as either victim, witness, or perpetrator, underscore the need to integrate violence prevention into all MCH initiatives. Gender-based violence (domestic violence and sexual assault), is a particular risk for the MCH population. Violence occurs in multiple forms including bullying, community violence, violence against women, youth violence, and violence against infants. Violence and bullying disproportionately impacts women, minorities, and persons with disabilities. MDPH must continue as a leader in violence prevention efforts, viewing violence and bullying as a preventable public health issue. To address this priority, we will build upon existing programs to promote screening and referral in MCH-related programs, educate providers, increase public awareness, outreach to high-risk populations and collaborate with schools and other community partners, and support recent state legal and regulatory changes related to shaken baby syndrome, bullying, and youth violence.

This priority will be measured through two newly developed state measures: domestic and dating violence and school safety. The first will be measured through SPM5 (The percentage of School Based Health Center clients for whom an assessment for intimate partner/teen dating/sexual violence was done) and the second through SPM9 (The percentage of high school students having missed a school day due to feeling unsafe at or on the way to school).

Priority # 5: Support reproductive and sexual health by improving access to education and services

Trends in birth statistics, including teen pregnancy, use of reproductive assistance, and rates of sexually transmitted diseases illustrate the growing importance of appropriate sexual health choices for all age groups, including adolescents. MDPH has a critical role in addressing sexual health and needs to ensure it is addressed across programs. Almost a third of high school youth reported being sexually active in the last three months, and almost 39% of sexually active high school youth reported not using a condom during last sexual intercourse. The number of pregnancies among women aged 45 years and older is rising, a group that also is more likely to use reproductive assistance (29.6%). Family planning is needed to reduce teen or unintended pregnancy, and the sequelae of assisted reproductive technology on infant health and development need to be better understood and addressed.

This priority will be measured primarily through NPM8 (Teen births) and the continued SPM1 (The percentage of pregnancies among women age 18 and over that are intended). In addition, three new state measures will be related indicators: SPM2 (Promote emotional wellness), SPM3 (Female binge drinking), and SPM5 (Partner violence addressed at SBHC visits). */2012/* The proposed measure related to female binge drinking has been dropped, as the rate shows little or no secular trend and there are no new programs or initiatives being implemented that might affect it. Attention to alcohol use and referrals for available services remain a component of a number of

service programs. //2012//

Priority Need # 6: Improve the health and well-being of women in their childbearing years. Despite improving overall perinatal health outcomes in Massachusetts, racial/ethnic disparities are widening. Furthermore, LBW and infant mortality rates have not improved, adequacy of prenatal care has declined and infant/neonatal mortality has increased among Hispanic and Asian populations in the last decade. Analyses of these racial disparities show that eliminating the disparity between Whites and Blacks and Hispanics will improve birth outcomes overall. A woman's health status prior to becoming pregnant and between pregnancies is a key factor in her pregnancy outcome. Health promotion activities, freedom from domestic violence, food security and good nutrition, access to primary care and family planning, screening and interventions for risk-taking behaviors, oral health services, and good mental health are all critical to overall good family health.

This priority is continued from 2005. We will place emphasis on improving pre and interconception health of women by promoting healthy behaviors; addressing the impact of age on birth outcomes; and influencing policy and licensing requirements that reduce systems barriers. In addition, more extensive and sophisticated data analyses (such as a new Review of Infant Mortality or RIM) will be applied to decrease the incidence of preventable infant deaths in Massachusetts.

The priority will be measured through six different NPMs and a new SPM3 (The percentage of females ages 18 - 45 reporting binge drinking). SPM2 (Promoting emotional wellness) and SPM5 (Partner violence addressed in SBHC visits) are also applicable. //2012/ The proposed measure related to female binge drinking has been dropped, as the rate shows little or no secular trend and there are no new programs or initiatives being implemented that might affect it. Attention to alcohol use and referrals for available services remain a component of a number of service programs. //2012// **//2013/ in FY13, MHVI will be collecting data from home-visiting programs on the health of pregnant and parenting women. These data as well as the program evaluation will be used to measure this priority.//2013//**

Priority # 7: Reduce unintentional injury and promote healthy behavior choices for adolescents. Many high school students engage in risk behaviors that pose threats to their health and safety. Students who engage in one high-risk behavior are often likely to engage in other risky behaviors.

Unintentional injury accounts for the largest percentage of deaths among children and youth. As unintentional injuries are preventable, especially among adolescents, it is a critical public health issue. Furthermore, there is a strong documented link between risk factors and adolescent behaviors which can lead to multiple adverse outcomes. One risk behavior (e.g. drinking) can impact other health consequences (e.g. automobile injuries, dating violence), underscoring the link between risk factors and health outcomes. On the other hand, factors identified as "assets" or "resiliency factors" are associated with lower levels of one or more risk behaviors. A range of approaches, some focused on the individual and providers, and others on the environment, will continue. MCH providers are well positioned to provide clients with injury prevention messages and strategies. Also important are regulatory and public safety efforts, public awareness of risks and alternative behaviors and improving the statewide child fatality review process.

This priority is continued from 2005 and is tracked by SPM10 (The percentage of adolescents reporting no current use (in past 30 days) of either alcohol or illicit drugs) and a new SPM8 which covers a critical age gap left by NPM10 (Motor vehicle deaths ages 15-24). NPM10 captures the safety of children as pedestrians or with an adult driving, whereas SPM8 covers the adolescent as the driver. **//2013/ We are clarifying this year that our SPM8 is tracking motor vehicle occupant deaths ages 15-19 only, emphasizing the role of young drivers and their passengers on the mortality rate. //2013//**

Priority # 8: Expand medical home efforts to focus on systems building and securing access &

funding for children and youth

The medical home model is an ongoing focus of Title V and this priority highlights our broad strategy for promoting medical home to include all children, in an effort to improve overall healthcare and engage a wider range of stakeholders. This is in line with new initiatives at the Secretariat level to develop and promote the medical home model across the entire population using public health care funds. Fewer than half of CYSHCN in Massachusetts met the NPM standard for medical home in the last survey.

A number of activities will be implemented to enhance the medical home concept including expanding MDPH practice-based care coordination to strengthen and expand medical home model in medical practices; demonstrating the effectiveness of medical home for CYSHCN, their families and providers; strengthening our capacity to train/mentor primary care providers to include medical home in their practices; developing standards and offering medical home certification to pediatric practices that implement them; promoting reimbursement by insurers for strategies that support the medical home model; and increasing family involvement in promoting medical home.

This priority will be measured by NPMs 4, 6, and 13 and a new SPM7 (The rate (per 100,000) of hospitalizations due to asthma among Black, non-Hispanic and Hispanic children aged 0-4 years). The new measure, related to Health Systems Capacity Indicator # 1 will help monitor and highlight disparities in services for children without a medical home.

Priority Need # 9: Support effective transitions from (1) early childhood to school and (2) adolescence to adulthood for children and youth with special health care needs
Compared with other NSCSHCN-measured outcomes, transition stands out as problematic. Health professionals can play a critical role but fewer than half of Massachusetts respondents said their doctors provided guidance and support on transition in the last survey, suggesting substantial room for improvement. The stakes for youth are substantial, given the relationships between disabilities, workforce participation, poor adult health, lower income, and other disparities.

Stakeholders with expertise in CYSHCN all named transition for CYSHCN to adulthood as a priority. Transition from early childhood to school is also a priority reflecting the equally critical developmental importance of successful transition for children with special health needs from early childhood services. It also reflects the continuum of screening, referral and interventions needed to promote optimal early childhood development and have all children ready to learn as they enter school.

This systems-building priority will be measured through NPM6 (and to some degree by NPMs 2 -- 4 also). Early childhood transition for children at risk is one of the focus areas in SPM2 (Promoting emotional wellness). SPM7 (Asthma hospitalization disparities in young children) and, SPM10 (Adolescent substance abuse) may also address service transitions at these critical ages.

//2012/ As the lead agency for the new Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative, the Department established a multi-agency Task Force, co-chaired by the MDPH Medical Director and the Commissioner of the Department of Early Education and Care, and focused on establishing the community-based comprehensive systems across the state necessary to improve transitions for children birth through eight over the next several years.

//2012// **//2013/ We are now also a partner with the Department of Early Education and Care in implementing the newly-awarded Race to the Top Early Learning Challenge Grant.**

//2013//

Priority Need # 10: Improve data availability, access and analytical capacity

Data access will continue as a priority for Massachusetts. We recognize the importance of linked datasets and data access for the community to support local program development. BFHN has developed a sophisticated capacity for electronic data collection and dissemination. We have

developed and are using unique and innovative linked datasets such as the Pregnancy to Early Life Longitudinal (PELL) Data System. However, there are still opportunities to create even more comprehensive, timely, and flexible data systems which could increase our understanding of populations to improve marketing, service and outreach, track youth aged 3 years and older and across generations; expand use of data for performance-based management of programs; further original research supporting evidence-based policies; and build upon PELL to show outcomes across program activities and improve longitudinal analysis of outcomes.

Improved data availability, access, and analytical capacity will not be measured directly by any NPM or SPM. Instead, it will be part of the NPM, SPM, HSCI, and HSI data collection processes and reporting. Many aspects of this capacity will be specifically reflected in Health Systems Capacity Indicator #09.

//2012/ Bureau staff are actively engaged with the Dept. of Early Education and Care in the identification and implementation of a shared database. This data sharing agreement will require parental consent and be designed to make families aware of multiple state services for which they may be eligible. Additionally, the database will allow for smoother programmatic transitions and offer opportunities for better longitudinal projections of need.//2012//

//2013/ With CDC funding for the Core PELL grant ending in September, 2012, MDPH and the ODT are assuming the lead role in the expanding PELL system. We will now provide partial replacement funding for our colleagues at BU School of Public Health and MGH, while continuing to explore additional funding and support opportunities. //2013//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-------|--|--|--|--|
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |
| Annual Indicator | 100.0 | 99.2 | 100.0 | 100.0 | 100.0 |
| Numerator | 115 | 119 | 149 | 128 | 155 |
| Denominator | 115 | 120 | 149 | 128 | 155 |
| Data Source | | New Eng Regional Newborn Screening Program | New Eng Regional Newborn Screening Program | New Eng Regional Newborn Screening Program | New Eng Regional Newborn Screening Program |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot | | | | | |

| | | | | | |
|-----------------------------------|-------------|-------------|-------------|-------------|-------------|
| be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |

Notes - 2011

Data on Newborn Screening from the New England Newborn Screening Program (NENSP) at the University of Massachusetts Medical School. The data are for Calendar Year 2011. The NENSP provides all these newborn screening services and furnishes these data. See Form 06 and its Notes also. Effective February 2009, Massachusetts screened every newborn for 30 disorders (listed below); these screens may show information about 23 additional disorders/conditions (by-products of mandatory screening).

- (1) Argininemia (ARG)
- (2) Argininosuccinic acidemia (ASA)
- (3) β -Ketothiolase deficiency (BKT)
- (4) Biotinidase deficiency (BIOT)
- (5) Carbamoylphosphate synthetase deficiency (CPS)
- (6) Carnitine uptake defect (CUD)
- (7) Citrullinemia (CIT)
- (8) Congenital adrenal hyperplasia (CAH)
- (9) Congenital hypothyroidism (CH)
- (10) Congenital toxoplasmosis (TOXO)
- (11) Cystic fibrosis (CF)
- (12) Galactosemia (GALT)
- (13) Glutaric acidemia type I (GAI)
- (14) Homocystinuria (HCY)
- (15) 3-hydroxy-3-methyl glutaric aciduria (HMG)
- (16) Isovaleric acidemia (IVA)
- (17) Long-chain L-3-OH acyl-CoA dehydrogenase deficiency (LCHAD)
- (18) Maple syrup disease (MSUD)
- (19) Ornithine transcarbamylase deficiency (OTC)
- (20) Phenylketonuria (PKU)
- (21) Sickle cell anemia (Hb SS)
- (22) Hb S/C disease (Hb SC)
- (23) Hb S/ β -thalassemia (Hb S/ β Th)
- (24) Medium-chain acyl-CoA dehydrogenase deficiency (MCAD)
- (25) Methylmalonic acidemia: mutase deficiency (MUT)
- (26) Methylmalonic acidemia: cobalamin A, B (Cbl A,B)
- (27) Methylmalonic acidemia: cobalamin C, D (Cbl C,D)
- (28) Propionic acidemia (PROP)
- (29) Tyrosinemia type I (TYR I)
- (30) Very long-chain acyl-CoA dehydrogenase deficiency (VLCAD)

Every newborn with abnormal results is tracked to a normal result or appropriate clinical care. In 2011, the total of 155 confirmed cases from mandated screening receiving treatment included 1 with PKU (plus 4 additional with "Atypical PKU), 73 with Congenital Hypothyroidism, 23 with Sickle cell disease (Hb SS), 11 with Hemoglobin S/C disease (Hb SC), 2 Hb S/ β -thalassemia (Hb S/ β Th), 16 with Cystic Fibrosis, , 9 with Congenital Adrenal Hyperplasia, 2 with Argininosuccinic acidemia (ASA), 9 with Biotinidase deficiency (BIOT), 1 with Maple syrup disease (MSUD), 2 with MCAD, 1 with VLCAD, 3 with Carnitine uptake defect (CUD), 1 with glutaric acidemia type I (GAI1), and 1 with isovaleric acidemia (IVA). Of these newborns with abnormal results, 39 were also identified with by-products of the mandatory screens and received appropriate treatment (2 3MCC, 11 SCAD, and 26 non-sickling forms of hemoglobinopathies) .

Notes - 2010

Data on Newborn Screening from the New England Newborn Screening Program (NENSP) at the University of Massachusetts Medical School. The data are for Calendar Year 2010. The NENSP provides all these newborn screening services and furnishes these data. See Form 06 and its Notes also. Effective February 2009, Massachusetts screened every newborn for 30 disorders; these screens may show information about 23 additional disorders/conditions (by-products of mandatory screening). Every newborn with abnormal results is tracked to a normal result or appropriate clinical care.

In 2010, the total of 128 confirmed cases from mandated screening receiving treatment included 3 with PKU, 55 with Congenital Hypothyroidism, 24 with Sickle cell disease (Hb SS), 12 with Hemoglobin S/C disease (Hb SC), 1 Hb S/ β -thalassemia (Hb S/ β Th), 19 with Cystic Fibrosis, 4 with Congenital Toxoplasmosis, 2 with Congenital Adrenal Hyperplasia, 1 with Argininosuccinic acidemia (ASA), 1 with Biotinidase deficiency (BIOT), 1 with Maple syrup disease (MSUD), 3 with MCAD, 1 with VLCAD, and 1 with Carnitine uptake deficiency (CUD). Of these newborns with abnormal results, 25 were also identified with metabolic by-products of the mandatory screens and received appropriate treatment (16 SCAD, 7 3MCC, and 2 Hypermethioninemia).

Notes - 2009

Data on Newborn Screening from the New England Newborn Screening Program (NENSP) at the University of Massachusetts Medical School. The data are for Calendar Year 2009. The NENSP provides all these newborn screening services and furnishes these data. See Form 06 and its Notes also. Effective February 2009, Massachusetts screened every newborn for 30 disorders (an expansion under new state regulations from 10); these screens may show information about 23 additional disorders/conditions (by-products of mandatory screening). Every newborn with abnormal results is tracked to a normal result or appropriate clinical care.

In 2009, the total of 149 confirmed cases from mandated screening receiving treatment included 7 with PKU, 65 with Congenital Hypothyroidism, 1 with Galactosemia, 26 with Sickle cell disease (Hb SS), 8 with Hemoglobin S/C disease (Hb SC), 22 with Cystic Fibrosis, 1 with Congenital Toxoplasmosis, 3 with Congenital Adrenal Hyperplasia, 6 with MCAD, 5 with VLCAD, 1 with Carnitine uptake deficiency (CUD), 1 with Homocystinuria, 1 with Ornithine transcarbamylase deficiency, 1 with Methylmalonic acidemia: mutase deficiency, and 1 with Methylmalonic acidemia: cobalamin C,D (Cbl C,D). Of these newborns with abnormal results, 17 were also identified with metabolic by-products of the mandatory screens and received appropriate treatment (11 SCAD, 5 3MCC, and 1 Hypermethioninemia).

a. Last Year's Accomplishments

See also NPM #12.

Massachusetts screened all births for 30 routine mandatory screenings and these screenings may show information on approx. 23 additional disorders/conditions (by-products of mandatory screening). There were 2 optional screens (pilot studies) that required consent from parents --Severe Combined Immune Deficiency (SCID) and MET - Fatty Acid Oxidation Disorders (a panel of an additional five metabolic disorders). 2011 data indicated that >99% of families participated in the voluntary testing.

Every newborn with abnormal results is tracked to a normal result or appropriate clinical care. In 2011, the total of 155 confirmed cases from mandated screening receiving treatment included 1 with PKU (plus 4 additional with "Atypical PKU), 73 with Congenital Hypothyroidism, 23 with Sickle cell disease (Hb SS), 11 with Hemoglobin S/C disease (Hb SC), 2 Hb S/ β -thalassemia (Hb S/ β Th), 16 with Cystic Fibrosis, 9 with Congenital

Adrenal Hyperplasia, 2 with Argininosuccinic acidemia (ASA), 9 with Biotinidase deficiency (BIOT), 1 with Maple syrup disease (MSUD), 2 with MCAD, 1 with VLCAD, 3 with Carnitine uptake defect (CUD), 1 with glutaric acidemia type I (GAI1), and 1 with isovaleric acidemia (IVA). Of these newborns with abnormal results, 39 were also identified with by-products of the mandatory screens and received appropriate treatment (2 3MCC, 11 SCAD, and 26 non-sickling forms of hemoglobinopathies).

Two approaches were used to assure that all babies born in MA had blood specimens collected for newborn screening: First, a statewide check was made by NENSP staff using a series of data set algorithms comparing electronic birth certificate data with specimens received, finding babies over 2 weeks old with no specimens and following up to receive specimens. The second involved provider-focused checks. Electronic files are submitted to the NENSP from selected hospital NICUs, Community Health Centers, and pediatric practices with data on all babies either in their nursery or being seen in their pediatric practice. These files are electronically matched to specimens received; non-matched babies are reported back to get specimens.

DPH materials about its special health needs programs were distributed through NENSP; the programs are listed on the back of every newborn screen lab report, as well as on certain other faxed materials.

BFHN, NENSP and the DPH Legal Office continued to collaborate on issues related to long-term follow-up and to revisit policies on specimen storage and usage.

Active BFHN participation continues in activities related to the New England Regional Genetics Collaborative, including medical home and educational subcommittees, and the New England Regional Genetics Board.

The NENSP selected the vendor to replace its current LIMS data system.

Two ongoing projects funded through the New England Genetics Collaborative (NEGC) grant are nearing completion: 1) long term follow-up (LTFU) (including a regional component to coordinate data on affected infants across New England, and 2) an inter-regional analysis to improve the quality of tandem mass spectrometry results interpretation and reporting.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Assure collection of blood specimens from all MA births by identifying any missing specimens through electronic matching of | | | X | |

| | | | | |
|---|--|---|---|---|
| received specimens with (1) provider-submitted birth records and (2) statewide electronic birth certificates. | | | | |
| 2. Screen all newborns (mandated) for 30 treatable disorders, through the New England Newborn Screening Program. | | | X | |
| 3. Optionally screen for 1 additional metabolic panel, plus SCID through 2 pilot programs; monitor over time to recommend any additional mandated screenings. | | | X | |
| 4. Track every newborn with abnormal results to a normal result or appropriate clinical care and, with other New England states, plan to carry out Long Term Follow-Up (LTFU) project for continued access to care. | | | X | X |
| 5. Perform regular quality improvement activities to assure all babies are screened and that affected infants and children have continued access to care (LTFU activities). | | | | X |
| 6. Continue Bureau of Family Health and Nutrition (BFHN) and NENSP collaboration to assure ongoing linkages of families to comprehensive services. | | X | | X |
| 7. Work toward improved integration of genetics and newborn screening. | | | | X |
| 8. Regularly convene and maintain staffing for the DPH Newborn Screening Advisory Committee meetings and special forums to promote high quality newborn screening and follow-up and continuous improvement in the state system. | | | | X |
| 9. Through regional collaboration, address newborn blood (and hearing) screening issues for "border babies" residing in MA but born in neighboring states, and vice versa. | | | | X |
| 10. Increase consumer and provider knowledge and access to newborn screening and genetics information and services, including workshops, phone consultation and distribution of printed materials for mandated and optional screenings. | | | | X |

b. Current Activities

The BFHN, NENSP and the DPH Legal Office finalized an updated policy to address the storage and use of specimens residual to the newborn blood screening program. This policy was implemented 10/15/2011. The blood screening card was redesigned to permit separation of the blood spot from personal identifiers (names, addresses, etc.) for long term storage. Thus, beginning with specimens received 10/15/11, all demographic information is removed from the collection card before storage; only filter paper serial number and the lab ID number are stored with the sample.

Active BFHN participation continues in activities related to the New England Regional Genetics Collaborative, including medical home and educational subcommittees, and the New England Regional Genetics Group.

The NENSP completed contract negotiations with the vendor that will provide the replacement for the NENSP laboratory information system. Configuration requirements are being collected.

The new Birth Defects, NENSP, and UNHSP brochure was finalized, translated into Spanish and Portuguese, and printed for distribution to birth facilities and other stakeholders in MA.

Mid 2011, parent-targeted brochures introducing the MA Immunization Information System were distributed to all birth hospitals along with the above-mentioned newborn screening parent brochures, and the newborn screening blood collection devices. This provided an efficient mechanism to distribute these materials to families of newborns.

c. Plan for the Coming Year

See also NPM #12. Continue ongoing activities.

Every MA birth will receive 30 routine mandatory screenings and these screenings may show information on approx. 23 additional disorders/conditions (by-products of mandatory screening). Parents will be offered the 2 optional screens (pilot studies) that require parental consent - Severe Combined Immune Deficiency (SCID) and MET - Fatty Acid Oxidation Disorders. The NENSP tracks every newborn with an abnormal screening result to a normal result or appropriate clinical care when diagnosed with a disorder.

The NBS Advisory Committee will meet to review screening panel data and make further recommendations. In collaboration with the DPH Commissioner, Legal Office, and CYSHN Program, efforts will be pursued to strengthen the NBS Advisory Committee by adding new clinical members.

NENSP will continue to collaborate with UNHSP and CYSHN staff to ensure families and providers are educated about state resources and programs available to identified infants and their families.

Long-term follow-up data will continue to be tracked to better understand screening conditions and long-term outcomes, including working with other New England states to integrate long-term data regionally.

Validation and implementation of the new NENSP LIMS system will continue. Implementation is expected sometime in 2013. Improvements expected include: improved management of specimen identification throughout the process, data merging, QC, HIE, and analytic functionalities. The NENSP then expects to have the infrastructure in place to have the capacity to electronically transmit newborn screening results using standardized HIE formats. Implementation will depend on capacities of clients (hospitals, for example) to receive such transmissions, and implementation of electronic interfaces.

Additional Emergency Preparedness activities are being planned to further increase the robustness of the NENSP emergency back-up capabilities, and to engage UMass and State agencies in activities that will assure integration of efforts related to newborn screening and follow-up during emergencies.

Newborn Hearing Screening Program Director will continue working with the NBS Advisory Committee, NEGC, NEGC

Medical Home Working Group, and NERGG Board as MA representative.

The Bureau will begin to explore the feasibility of integrating NBS data with PELL.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

| | | | | | | |
|---|--|------|--|--|--|-------|
| Total Births by Occurrence: | 73508 | | | | | |
| Reporting Year: | 2011 | | | | | |
| Type of Screening Tests: | (A) Receiving at least one Screen (1) | | (B) No. of Presumptive Positive Screens | (C) No. Confirmed Cases (2) | (D) Needing Treatment that Received Treatment (3) | |
| | No. | % | No. | No. | No. | % |
| Phenylketonuria (Classical) | 73182 | 99.6 | 142 | 1 | 1 | 100.0 |
| Congenital Hypothyroidism (Classical) | 73182 | 99.6 | 1007 | 73 | 73 | 100.0 |
| Galactosemia (Classical) | 73182 | 99.6 | 30 | 0 | 0 | |
| Sickle Cell Disease | 73182 | 99.6 | 23 | 23 | 23 | 100.0 |
| Biotinidase Deficiency | 73182 | 99.6 | 30 | 9 | 9 | 100.0 |
| Cystic Fibrosis | 73182 | 99.6 | 242 | 16 | 16 | 100.0 |
| Homocystinuria | 73182 | 99.6 | 218 | 0 | 0 | |
| Maple Syrup Urine Disease | 73182 | 99.6 | 131 | 1 | 1 | 100.0 |
| beta-ketothiolase deficiency | 73182 | 99.6 | 2 | 0 | 0 | |
| Tyrosinemia Type I | 73182 | 99.6 | 0 | 0 | 0 | |
| Very Long-Chain Acyl-CoA Dehydrogenase Deficiency | 73182 | 99.6 | 23 | 1 | 1 | 100.0 |
| Argininosuccinic Acidemia | 73182 | 99.6 | 3 | 2 | 2 | 100.0 |
| Citrullinemia | 73182 | 99.6 | 0 | 0 | 0 | |
| Isovaleric Acidemia | 73182 | 99.6 | 13 | 1 | 1 | 100.0 |
| Propionic Acidemia | 73182 | 99.6 | 27 | 0 | 0 | |
| Carnitine Uptake Defect | 73182 | 99.6 | 11 | 3 | 3 | 100.0 |
| Ornithine Transcarbamylase Deficiency (OTC) | 73182 | 99.6 | 4 | 0 | 0 | |
| Methylmalonic | 73182 | 99.6 | 27 | 0 | 0 | |

| | | | | | | |
|--|-------|------|-----|----|----|-------|
| acidemia (Cbl A,B) | | | | | | |
| Glutaric Acidemia Type I | 73182 | 99.6 | 6 | 1 | 1 | 100.0 |
| 21-Hydroxylase Deficient Congenital Adrenal Hyperplasia | 73182 | 99.6 | 308 | 9 | 9 | 100.0 |
| Medium-Chain Acyl-CoA Dehydrogenase Deficiency | 73182 | 99.6 | 26 | 2 | 2 | 100.0 |
| Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency | 73182 | 99.6 | 0 | 0 | 0 | |
| 3-Hydroxy 3-Methyl Glutaric Aciduria | 73182 | 99.6 | 0 | 0 | 0 | |
| Methylmalonic Acidemia (Mutase Deficiency) | 73182 | 99.6 | 27 | 0 | 0 | |
| S-Beta Thalassemia | 73182 | 99.6 | 2 | 2 | 2 | 100.0 |
| Argininemia (Arg) | 73182 | 99.6 | 67 | 0 | 0 | |
| Optional Pilot Study screens (MET and SCID) | 72748 | 99.0 | 137 | 3 | 3 | 100.0 |
| Carbamoylphosphate synthetase deficiency (CPS) | 73182 | 99.6 | 4 | 0 | 0 | |
| Congenital toxoplasmosis (TOXO) | 73182 | 99.6 | 6 | 0 | 0 | |
| Hb S/C disease (Hb SC) | 73182 | 99.6 | 11 | 11 | 11 | 100.0 |
| Methylmalonic acidemia: cobalamin C, D (Cbl C,D) | 73182 | 99.6 | 27 | 0 | 0 | |
| PKU Monitoring | 157 | | 0 | 0 | 0 | |

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|--|-------------|---------------------------|---------------------------|---------------------------|---------------------------|
| Annual Performance Objective | 72 | 59 | 60 | 61 | 63 |
| Annual Indicator | 57.1 | 57.1 | 57.1 | 74.1 | 74.1 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | NS-CSHCN, 2005-2006 (part | NS-CSHCN, 2005-2006 (part | NS-CSHCN, 2009-2010 (part | NS-CSHCN, 2009-2010 (part |

| | | of NCHS/SLAITS) | of NCHS/SLAITS) | of NCHS/SLAITS) | of NCHS/SLAITS) |
|---|-------------|--------------------|--------------------|--------------------|--------------------|
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 74.1 | 76 | 77 | 78 | 78 |

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Massachusetts has adjusted our projections using the latest survey data as a baseline. The Massachusetts rate is higher than the U.S. rate of 70.3% but not significantly so.

Notes - 2010

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2009

There are no updated state-level data for 2009. Data are from the National Survey of Children with Special Health Care Needs (NS-CSHCN), 2005-2006 conducted as part of NCHS/SLAITS. For the 2005-2006 survey, Massachusetts was comparable to the nation; the national figure was 57.4 (CI: 56.5-58.2).

a. Last Year's Accomplishments

The Director of Family Initiatives (DFI) and Family TIES worked collaboratively to recruit and mentor Family Advisors (FAs) to review new CYSHCN Program materials to ensure relevance and user-friendliness, provide input into Chapter 171 Family Support Plan and Block Grant updates, participate in RFR reviews, and serve on Department-wide advisories. Currently 156 parents of children with special health needs have self-identified as Family Advisors. Efforts to engage diverse families as advisors continued. Over 40 identified themselves as having diverse cultural backgrounds, including Hispanic, Haitian, Vietnamese, Chinese and African. FAs provided input into the Spanish and Portuguese versions of the CYSHCN Program brochure. Family members who participated in any advisory functions received stipends and mentoring to support their involvement.

Over 800 parents attended the annual Federation for Children with Special Needs statewide parent/professional conference co-sponsored by Family TIES and the Early Intervention Parent Leadership Project (EIPLP). 150 family members responded to the annual DPH Chapter 171 survey providing information about unmet and under-met public health needs and community based systems of care. Information gathered at this and other venues informed the MA mandated "Family Support Plan." Among other areas, families indicated a desire for more information about and access to medical home. Follow up fact sheets, informational links to websites and other materials were made available to families and distributed to providers, training programs and academic institutions.

The EIPLP celebrated 20 years of outreach, training and support to families whose children received EI services. At a DPH sponsored dinner, close to 100 families shared pictures, stories and information about how they used skills fostered by EIPLP activities and staff to take on advocacy roles for their own and other children and families. Many reported better ability to communicate with their children's schools, health care providers and community resources. Others talked about service on local school boards, PTOs and advisory bodies at hospitals, and about education and careers that grew out of skills and encouragement provided by EIPLP.

EIPLP participated in training for EI staff to orient them to resources for family involvement, provided 238 informational packets, and participated in the development of three on-line workshops for parents and EI staff.

Four editions of the Parent Perspective newsletter, themed, "Parent Leadership is for Everyone: Engaging Diverse Families as Leaders," were disseminated to over 8700 families and professionals. EIPLP received 33 calls on its toll free line, 446 calls on office lines, 2600 emails, and 54,000 website hits.

Family TIES and EIPLP offered in-person training and outreach to over 5000 families and professionals, including 900 families for whom English is not their first language. The Parent-to-Parent program was able to complete 53 new matches. P-to-P Listen and Learn curriculum for mentor parents was translated into Vietnamese and Chinese. A new P-to-P director was hired.

Contacts and collaborations were established and/or deepened with more than 50 CBOs including presentations at health fairs, parent groups and local public health groups. Connections were made statewide with Somali, Eritrean, Arabic, Southeast Asian, Haitian, Hispanic and Portuguese families and CBOs serving them.

Office of Family Initiatives and EIPLP staff worked to identify parents to create digital stories to be used as training tools for EI and special health needs communities. Work continued to identify and support Parent Contacts in EI programs statewide.

9000 NCSEAM Family Surveys measuring the extent to which families feel that EI services have a positive impact on their children and families were distributed and 2776 returned by families receiving EI services.

Care Coordinators (CCs) working in medical practices identified and supported 22 Family Consultants (as stipended positions) to serve as part of the Medical Home Team and provide leadership on practice improvement initiatives.

For the first time, a parent of a CSHCN was appointed by the Attorney General and Governor to the Catastrophic Illness in Children Relief Fund Commission.

Family members participated on the proposal review team, as part of the Pediatric Palliative Care Network (PPCN) RFR process to identify new providers.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. The Division for Perinatal, Early Childhood and Special Health Needs (DPECSHN) and its Family Initiatives (FI) Director provide leadership for DPECSHN, BFHN, and other state agency programs to enhance and extend consumer and family participation. | | | | X |

| | | | | |
|---|--|--|--|---|
| 2. Increase diversity of family participants, in particular through two FI programs: Family TIES and Early Intervention Parent Leadership Projects (EIPLP). | | | | X |
| 3. Hire family members and consumers as paid staff/consultants to the state CYSHCN programs. | | | | X |
| 4. Support parents' active participation in advisory groups, including EI, Universal Newborn Hearing Screening, MassCARE and New England Regional Genetics Group (NERGG). | | | | X |
| 5. In collaboration with Family Voices, the Director of Family Initiatives presents information about the MCH Block Grant to family leaders and obtains family input through multiple avenues. | | | | X |
| 6. Provide parent support and training, including stipends, and collaborate with the Federation for CSN to develop parent participation and leadership. Offer parents opportunities to participate in all Family Initiatives as well as other DPH programs. | | | | X |
| 7. Through the Care Coordination Program (CC) for CSHCN, increase opportunities in pediatric practices for parent-professional partnering, including development of parent advisory groups and other systems for family participation. | | | | X |
| 8. Require parent participation in School Health Advisory Committees in Essential School Health Services (ESHS) program sites. | | | | X |
| 9. DPEC SHN continues to make available through the web and promote use of a resource and recordkeeping tool, "Directions: Resources for Your Child's Care" to families of CYSHCN and providers, in English, Spanish and Portuguese. | | | | X |
| 10. Survey families and youth accessing DPH-funded services and supports, including Community Support, Family TIES, School Based Health Centers, ESHS, EI, MASSTART and Pedi Palliative Care to assess satisfaction and impact. | | | | X |

b. Current Activities

See Summary Sheet and NPMs #3, 4, 5, 6, and 12.

DFI provided training and information to LEND Fellows at E.K. Shriver Center and UMass Boston/Children's Hospital about Title V MCH and CYSHCN Programs and about family involvement activities.

DFI works with the MCH concentration at Harvard School of Public Health to embed knowledge of Title V and family-centered care into curriculum. In FY 12, an additional component, practicum opportunities for students, was added. HSPH MCH concentrators are assisting in developing an evaluation for our Care Coordination program and working to develop materials for families on on-line health literacy.

DFI represents MDPH on numerous Advisory Boards, including the Institute for Community Inclusion, and Pediatric Physicians Org of Children's Hospital, sharing information about CYSHCN Program priorities, including spread of Medical Home.

DFI served on a steering committee to EOHHS considering the creation of a new children's agency. DFI provided a

family perspective for CYSHCN to the committee.

UNHS Program and OFI collaborated to support over 40 parents to attend a biennial conference, Next Steps, sponsored by Children's Hospital; held an annual Family Forum attended by numerous parents; and supported a parent to attend the national EHDI conference.

CC Program, through its collaboration on the MA CHIPRA demonstration project, is assisting each of 13 practices to establish a functioning parent advisory structure.

c. Plan for the Coming Year

See Summary Sheet and NPMs #3, 4, 5, 6, and 12. Continue ongoing activities.

Reorganize EIPLP to regain a program based focus that will grow the Parent Contact network and provide program directors and staff with supports to enhance family involvement.

Continue to expand collaboration with Harvard School of Public Health to effectively evaluate and document outcomes and impact of family engagement within the CYSHCN program and across the Bureau.

Deepen relationships with families from diverse cultures and languages at the community level and identify opportunities for those families to serve as advisors to the CYSHCN Program.

Work in collaboration with the Family-to-Family Health Information Center at the Federation for Children with Special Needs to share information about Title V and Medical Home. Use this collaboration and resources to expand family engagement within community based pediatric practices.

Identify new opportunities for OFI staff to collaborate and share information about family engagement with other Bureau and broader DPH programs.

Continue to support families from diverse cultures whose first language is not English to become trainers for the Family TIES Parent-to-Parent program.

DFI and other OFI staff will continue to work closely with UNHS program to broaden and enhance Family Support activities, including specific activities for fathers, teens and families of older children with hearing loss. - See NPM 12.

Expand family engagement activities within the PPCN.

An "MDPH Annual Family Support Plan for FY 2013" will be finalized and distributed to the legislature and public, as part of a composite report filed by EOHHS. This plan is in compliance with state Chapter 171 of the Acts of 2002: An Act Providing Support to Individuals with Disabilities and Their Families.

The CC Program, working with 13 CHIPRA practices, will continue to promote the Family Consultant model in its Medical Home project.

Based on the survey results, Care Coordination program will evaluate and implement policy and/or other changes to the provision of services.

Continue ongoing ESHS client satisfaction survey on schedule to survey one-third of districts annually.

Develop and administer a survey to assess family satisfaction with the CICRF.

MassCARE will continue to implement a new model with an HIV Medical Home approach, and performance measurement on medical home, using the NCQA standards for patient-centered medical home.

The PPCN will continue to hold conference call focus groups (in English and Spanish) with families whose children are part of the PPCN. This was begun in FY12, to inform development of the RFR for new providers for FY13. The goal of ongoing calls is to survey families about their experience, preferences and satisfaction with services, and make program adjustments as needed.

Continue ESHS client satisfaction surveys as funding permits.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-------------|---|---|---|---|
| Annual Performance Objective | 67 | 47 | 49 | 51 | 53 |
| Annual Indicator | 45.7 | 45.7 | 45.7 | 47.1 | 47.1 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | NS-CSHCN, 2005-2006 (part of NCHS/SLAITS) | NS-CSHCN, 2005-2006 (part of NCHS/SLAITS) | NS-CSHCN, 2009-2010 (part of NCHS/SLAITS) | NS-CSHCN, 2009-2010 (part of NCHS/SLAITS) |
| Check this box if you cannot report the numerator because | | | | | |

| | | | | | |
|---|-------------|-------------|-------------|-------------|-------------|
| 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 47.1 | 50 | 50 | 54 | 54 |

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Massachusetts has not improved as much as we had hoped since 2006. We have adjusted our projections using the latest survey data as a new baseline. The Massachusetts rate is higher than the U.S. rate of 43.0% but not significantly so.

Notes - 2010

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2009

There are no updated state-level data for 2009. Data are from the National Survey of Children with Special Health Care Needs (NS-CSHCN), 2005-2006 conducted as part of NCHS/SLAITS.

The comparable national figure was 47.1% (CI: 46.3-48.0) for 2005-2006. The CI for Massachusetts for 2005-06 was 41.4-50.0, suggesting no statistical difference between Massachusetts and the nation.

a. Last Year's Accomplishments

Care Coordinators were co-located in 15 pediatric primary care practices across the state as part of its Medical Home

Project, to promote the medical home model. Care Coordinators for CYSHCN provided care coordination services to

549 families of CYSHCN statewide in FY11. Care coordinators help physicians provide family-centered care, develop

care plans and establish office systems to improve quality of care. They identified and referred CYSHCN; helped

families optimize insurance coverage, access public benefits, find parent to parent support, and become better

advocates; attended school meetings; and assisted with transition activities.

The Care Coordination Program Director served on the selection committee for the CHIPRA Medical Home Project

(part of a larger CHIPRA Quality Demonstration Grant). She was also on the selection committee for a MA EOHHS

project (the MA Patient Centered Medical Home Initiative) to develop medical home in all practices in the state, for all

populations. 67 practices were selected to participate.

The Care Coordination Program collaborated with the CHIPRA Medical Home demonstration project to spread

medical home across all populations in community health centers, including two where DPH Care Coordinators were located.

The Care Coordination project held its fourth annual Conversations in Medical Home Best Practices meeting. 40

providers and 10 family members participated.

DPH finalized and began distribution of a position paper on Medical Home.

School nurses (ESHS) arranged 95,081 primary care appointments for students during the school year; about 7.6%

of referrals were for students who did not yet have providers.

The Essential School Health Service Performance Improvement (evaluation/CQI) Committee, comprised of 25 nurse

leaders that meet monthly, has had a project that includes parent education on the triggers of asthma to determine

if health office visits decrease. The project demonstrated that with school nurses providing information on trigger

avoidance and follow up phone calls to parents, the number of student visits to the nurse's office for asthma

treatment decreased by 50%. An article is being written to share the findings. In addition, efforts are being made to

increase the emphasis on primary prevention during childhood of chronic diseases; unfortunately much grant funding

has thus far focused on adults.

Another CQI project on diabetes care in the schools continued.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. DPECSHN Care Coordinators for CYSHCN, housed in primary care practices and DPH Regional Offices, respond to referrals from the practices and community sources and help practices develop components of a medical home model. | | X | | X |
| 2. All BFHN programs serving children screen/refer for a regular primary care provider. | | X | | |
| 3. DPECSHN programs (including EI, MASSTART, Medical Review Team, CICRF, Pediatric Palliative Care, and Community Support) assess and link CYSHCN with care coordination and medical homes, if needed. | | X | | X |
| 4. DPECSHN programs and others in BFHN are charged to maintain effective coordination and collaboration with child's existing medical home. | | X | | X |
| 5. DPECSHN collaborates with primary pediatric practices both hospital-based and Federally-qualified community health centers to promote medical home concept. | | X | | X |
| 6. MassCARE Program offers care coordination services and links to primary and specialty care to all enrolled HIV-infected children and youth statewide through 5 community-based settings. | | | | X |
| 7. DPECSHN continues to make available via the web a resource & recordkeeping tool, "Directions: Resources for Your Child's Care," for families of CYSHCN & providers, to help parents build and use a medical home for their child. (in Eng., Span., Port.) | | | | X |
| 8. DPECSHN staff participate in the New England Regional Genetics Group (NERGG) medical home workgroup. | | | | X |
| 9. UNHSP staff verify that children referred through newborn hearing screening are linked to a PCP and staff work with the PCPs when families are at risk of not getting follow-up audiological services. | | X | | X |
| 10. Through the MHVI Program, BFHN links families receiving evidence-based home visiting to medical homes. | | X | | |

b. Current Activities

See Summary Sheet and NPMs #1, 2, 4, 5, 6 and 12.

The CYSHCN management group is working with the DPH Medical Director to promote the spread of medical home.

Care coordinators are located in 15 pediatric primary care practices across the state, including 3 community health centers (CHCs). Parent Consultants have been identified to support the medical home model and are supported through stipends and training at 14 practices. In collaboration with MA DPH School-Based Health Center (SBHC) Program, a Care Coordinator was placed in a SBHC through a pilot project begun in FY11.

The MassCARE program implemented a new model and new community sites; the model includes an HIV medical home approach.

The UNHSP Program Director participated in the Early Hearing Detection and Intervention National AAP Lost to Follow-up Workgroup to develop draft guidelines for hearing screening in medical homes.

The Pediatric Palliative Care Network director and providers, Care Coordinators, Family TIES staff, EI providers, and Regional Consultation Program directors meet together quarterly in their regions to coordinate and enhance services and coverage to families.

The ESHS diabetes care pilots continued; measurable outcomes are currently being analyzed. Grand rounds on the project are being held at Baystate Children's Hospital in June.

The Manual for the Care of the Child with Diabetes in the School Setting has been completed and distributed to schools.

c. Plan for the Coming Year

Continue ongoing activities.

BFHN will continue to participate actively with EOHHS and MassHealth in developing a state plan and policy for implementing the medical home concept for all age groups. The Care Coordination Program will continue to partner with the CHIPRA Medical Home Project and its 13 practices statewide. DPH Care Coordinators and the Medical Home Facilitator will offer on-site training, technical assistance, resources and Care Coordination services for these sites.

Collaboration among DPECSHN programs serving CYSHCN will continue with practice staff to enhance the role of care coordination, levels of service, and build the components of medical home in practices.

The Care Coordination Program's Medical Home Facilitator will continue to offer training at the primary care practice sites and offer additional Learning Sessions for practice staff on current trends and topics in medical home.

Care Coordinators will continue in 2 practices that are still under a "Memorandum of Understanding" with DPH, 1 of which has active parent/family involvement, along with the 13 CHIPRA practices.

The Care Coordination Program's Medical Home Facilitator, and 2 Care Coordinators will continue to participate actively in the Western MA Medical Home Consortium.

Family TIES coordinators will continue to support community pediatric practices with information

and referral and
provide training as requested around family participation and transition.

A Family Partner, recruited and trained through the Family-Professional Partners Institute (previously funded by the MCHB CYSHCN state implementation grant), will continue to work with a 17-member, community-based pediatric practice, to implement family involvement, care coordination and support around transition.

The UNHSP will continue to work closely with the MA Chapter of the AAP designated newborn hearing screening champion Jane Stewart, MD to ensure the needs of medical homes are included in program planning and implementation.

SBHC site visits review medical charts and individualized care plans for CYSHCN. Chart abstraction criteria include:
documentation of collaboration among specialty care providers; evidence of appropriate referrals; and
communication between PCP and specialists demonstrating continuity of care without service duplication. Charts sampled include 2 with chronic care services (e.g. asthma, diabetes) and 2 with mental health services.

MHVI Program staff will continue to work with contracted vendors in 17 high-need communities to link families receiving home visiting to medical homes, provide training to agency staff on the definition of medical home, and integrating medical homes into early childhood systems of care,. In one community (Chelsea), the MHVI program is based in a pediatric clinic that function as a medical home to their community.

A School Health report on BMI data from schools is in the Governor's office for approval and release during FY13.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---------------------------------------|------|-----------|-----------|-----------|-----------|
| Annual Performance Objective | 70 | 64 | 65 | 75 | 75 |
| Annual Indicator | 63.1 | 63.1 | 63.1 | 62.2 | 62.2 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | NS-CSHCN, | NS-CSHCN, | NS-CSHCN, | NS-CSHCN, |

| | | 2005-2006 (part of NCHS/SLAITS) | 2005-2006 (part of NCHS/SLAITS) | 2009-2010 (part of NCHS/SLAITS) | 2009-2010 (part of NCHS/SLAITS) |
|--|-------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 62.2 | 63 | 63 | 64 | 64 |

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Massachusetts has not improved as much as we had hoped since 2006, despite the implementation of universal health care reform in Massachusetts. This measure captures a number of items beyond health insurance coverage (which is over 98% for children), including the adequacy of insurance coverage and costs that are not met by insurance. The survey definition of "adequate" coverage sets more stringent criteria than what is measured in NPM # 13. Given this weighting, we have adjusted our projections using the latest survey data as a new baseline. The Massachusetts rate is higher than the U.S. rate of 60.2% but not significantly so. Like the rest of the country, there has been no improvement in this measure in the last decade.

Notes - 2010

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2009

There are no updated state-level data for 2009. Data are from the National Survey of Children with Special Health Care Needs (NS-CSHCN), 2005-2006 conducted as part of NCHS/SLAITS. Massachusetts was comparable to the nation at the time of the survey. The national figure was 62.0 (CI: 61.2-62.8) for 2005-2006.

a. Last Year's Accomplishments

See also NPMs #1 and 13.

The SSI/Public Benefits Program provided 18 training programs to 225 participants statewide of which 26.2% were parents. Others trained included community health providers, nurses, Early Intervention staff, case managers, pediatricians, graduate students/fellows, occupational and physical therapists and child state agency staff. Most technical assistance calls related to SSI/Public Benefits were received through the Community Support 800#. Nevertheless, the Public Benefits specialist responded to 157 calls for technical assistance, 35% of which were from parents/family members.

The Community Support 800 Line responded to 1459 technical assistance requests by phone or email, of which 49% (725) were from parents/family members. Community Support staff sent mailings to 200 families upon request with information and applications for public insurance programs. Staff also provided training on public benefits to 53 parents.

The CICRF provided approximately \$1.95 million in financial assistance to 248 families of CSHCN with extraordinarily high out-of-pocket medical or related expenses in relation to family income (expenses exceed 10% of annual family income). As a payor of last resort, CICRF assisted families with payment for needed items and services not covered by insurance, including home and vehicle modifications. CICRF also negotiated with insurers or located alternate resources for additional families, obviating the need for CICRF funding and assisting families who did not meet the 10% of income requirement.

During FY11, 16 uninsured or underinsured clients received special foods assistance through the PKU Special Medical Foods Program.

DPH Care Coordinators assisted 291 families through the Flexible Family Support Fund to reimburse costs of goods and services. Eligible expenses relate to raising a child with special health care needs. These expenses tend not to be medical in nature and are therefore not covered by regular health insurance.

Of children in EI, 99% have private and/or public health insurance. The remaining 1% received

state-funded EI services, and assistance was provided by EI staff to access, as appropriate, public health insurance benefits.

1224 families accessed durable medical equipment through the statewide Regional Consultation Programs (RCP) Equipment Loan Program. This is significantly more than FY10 (546). The increase is largely due to having a full complement of RCP directors in each region of the state and providing additional outreach to families.

The Pediatric Palliative Care Network (PPCN) contracted with 10 hospice programs to provide services to 229 children with life-limiting illness and their families, covering services not otherwise covered by insurance. With the enactment of the Concurrent Care for Children Hospice Benefit, families may elect the hospice benefit without giving up curative treatment. This legislation has not lessened on the demand for PPCN services, as the physician must still sign an order that the child has six months or less to live. PPCN provided \$700,850 in services for children and families, representing a \$20,000 increase from the previous year. Families most commonly used psychosocial support services, followed by complementary therapies, and volunteer services. Approximately 10% of families spoke a primary language other than English, including Spanish, Portuguese, Japanese, Mandarin, Polish, Arabic and Hindi.

The CICRF continued to make some policy adjustments to address the reduced funding and ensure sustainability of the Fund. Transfers into CICRF from the Medical Security Trust Fund (MSTF) were suspended in late FY09 due to lack of funds in the MSTF -- a result of economic downturn. In FY10 and FY11, CICRF operated on reserves from previous years. Elimination of some areas of coverage and reductions in reimbursement amounts were made in order to continue to serve as many families as possible and sustain the Fund until transfers are resumed. Additionally, the CICRF Commission asked the state legislature for assistance -- and was successful -- in identifying alternative funds for FY12 so the CICRF could remain in operation for FY12, since MSTF transfers were not expected to resume.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. All BFHN and other DPH programs with direct family contact are required to screen for health care access and insurance, make referrals and assist with enrollment and access. | | X | | |
| 2. The SSI/Public Benefits Coordinator trains providers and families of CYSHCN on eligibility, application processes and appeals for SSI, CommonHealth, Kaileigh Mulligan and | | X | | X |

| | | | | |
|---|---|---|--|---|
| MassHealth, and participates in related state-level coalitions/groups. | | | | |
| 3. DPH Family Support Fund helps families of CYSHCN pay for expenses related to their child's special health care needs that are not covered by health insurance or public benefits. | X | X | | |
| 4. The Catastrophic Illness in Children Relief Fund (CICRF) serves as a payor of last resort for eligible families of CYSHCN with extraordinary out-of-pocket medical and related expenses not covered by insurance or other sources. | | X | | |
| 5. The CICRF refers and provides technical assistance to access other resources (such as MassHealth; CommonHealth; MA Assistive Technology Loan Program; Home Modification Loan Program), assisting families eligible and not eligible for CICRF funding. | | X | | |
| 6. The Pediatric Palliative Care Network provides services not covered by insurance for symptom management, to improve quality of life, and to provide end-of-life care for children with life-limiting illness and their families. | X | X | | |
| 7. DPH Care Coordination for CSHCN provides families with assistance with accessing and optimizing health insurance benefits. Care Coordinators provide trainings on benefits and services regionally and in pediatric practice sites. | | X | | X |
| 8. State law mandates health care plans to cover newborn hearing screening and diagnostic follow-up and the state funds hearing aids for low income, uninsured or underinsured children. | | | | X |
| 9. Participate in the Children's Health Access and the Affordable Care Today (ACT) coalitions, which assess the percent of the population receiving adequate health coverage and actively monitor the effect of health reform on children, especially CYSHCN. | | | | X |
| 10. The Community Support 800# provides information and technical assistance about insurance programs for which families may be eligible and about programs that offset health costs not covered by insurance. | | X | | X |

b. Current Activities

See also Summary Sheet and NPMs #1 and 13.

The Title V Director represents DPH on the EOHHS Children's Behavioral Health Initiative (CBHI) to provide increased coverage for behavioral health services. He actively participates at the executive and Implementation levels of this initiative to promote increased coverage for developmental and behavioral services by all insurers.

The Office of Family Initiatives, Community Support Line and Public Benefits staff collaborate with the Mass Family-to-Family Health Information Center (F2F HIC), sharing referrals and information to support families around health insurance questions. The Director of Family Initiatives supports topical calls and sits on the Advisory Group, helping plan the annual conference for families.

The CICRF Commission continues to seek funds to support and sustain the Fund until transfers from the MSTF

resume. The Commission held an anniversary celebration at the State House to highlight for legislators the critical assistance the Fund has provided to families in the past 11 years. Two parents who received assistance from the Fund spoke at the event, as did a physician, the Senate President (who was given an award by the Commission), the State Treasurer and the DPH Commissioner.

c. Plan for the Coming Year

See also NPMs #1 and 13. Continue ongoing activities.

The SSI/Public Benefits Program, Care Coordination, EI, EIPP, school health, school-based health centers, FOR Families, Pediatric Palliative Care, and community health center based programs will continue to be key venues for health insurance access for CSHCN.

Continue to monitor impact of state and federal Health Care Reform on insurance coverage for CYSHCN and continue to assure current levels of and identify gaps in coverage.

The CICRF Commission will continue to explore additional source of funds in order to keep the CICRF in operation until transfers from the Medical Security Trust Fund resume.

If funding and staffing allow, CICRF will undertake an expanded outreach campaign in FY13, in order to increase awareness of the Fund as a resource for families with extraordinary medical and related expenses uncovered by any other private or public source.

See Summary Sheet items 4, 5, and 6 (related to CICRF and PPCN).

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 81 | 87.6 | 89.2 | 89.2 | 90 |
| Annual Indicator | 87.6 | 87.6 | 87.6 | 68.2 | 68.2 |
| Numerator | | | | | |

| | | | | | |
|--|-------------|--|--|--|--|
| Denominator | | | | | |
| Data Source | | NS-CSHCN, 2005-2006 (part of NCHS/SLAITS) | NS-CSHCN, 2005-2006 (part of NCHS/SLAITS) | NS-CSHCN, 2009-2010 (part of NCHS/SLAITS) | NS-CSHCN, 2009-2010 (part of NCHS/SLAITS) |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 68.2 | 69 | 69 | 70 | 70 |

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Massachusetts has adjusted our projections using the latest survey data as a baseline. The Massachusetts rate is higher than the U.S. rate of 65.1% but not significantly so.

Notes - 2010

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2009

There are no updated state-level data for 2009. Data are from the National Survey of Children with Special Health Care Needs (NS-CSHCN), 2005-2006 conducted as part of NCHS/SLAITS. The 95% Confidence Interval (CI) for the 2005-2006 for Massachusetts was 84.7-90.5; for the nation, it was 88.6-89.6 (point estimate 89.1). The CI's overlap; there was no statistical difference between Massachusetts and the nation.

a. Last Year's Accomplishments

See also NPMs #1, 2, 3, 4, 6, and 12.

DPECSHN's centralized Community Support Line fielded information and referral calls, provided service to 1452 callers of whom 725 were parents/family members. The Community Resource Specialists serve as a resource statewide to direct families and providers to all DPECSHN programs for CYSHCN and other DPH and state and community-based services.

Family TIES received 3082 calls, had a total of 9904 contacts with families and professionals and over 700,000 hits on its website. Staff distributed 9400 brochures in English, Spanish and Portuguese, 1,694 Resource Directories and a variety of tip sheets on topics such as autism, mental health, medical home and transition.

OFI staff provided training to colleagues in each regional office to increase awareness of family engagement strategies and value

DFI presented at a variety of meetings, conferences, advisory groups about Title V CYSHCN Program to inform and to extend opportunities to collaborate in systems enhancement activities.

Care Coordination and Family TIES staff continued to collaborate with community programs to sponsor "Understanding Services for CYSHCN" across the state, sharing information about resources and systems of care with families and providers.

The EI Training Center and the EIPLP developed training modules for families enrolled in EI: EI Overview; IFSP Process; Family Rights and Due Process; and Parent Leadership. The modules provide an opportunity to share information about the EI system with families and support them in understanding their rights and ways to communicate their child's needs effectively.

Family TIES staff worked with 50 CBOs to build community based relationships with families from diverse cultural and linguistic backgrounds, sharing information about state resources and systems of care.

A new CYSHCN Program brochure to increase awareness about CYSHCN Program and promote the Community Support Line as the place to call for assistance was finalized and printed. Widespread distribution of the brochure began. With input from native Spanish and Portuguese speaking parents, translated, finalized and printed Spanish and Portuguese versions of the brochure.

Regional Consultation Programs (RCPs), with funding from the Department of Early Education and Care, made 44 consultation visits to community-based preschool programs and 32 consultations to child care educators to facilitate the inclusion of children with complex medical needs and to offer training and support to families at the community level. 370 preschool staff and 1,591 childcare staff were trained at RCP trainings on topics that included talking with families, addressing challenging behaviors, feeding issues, assistive and augmentative communication and inclusion.

An MOU is in place and staff actively collaborate to facilitate referrals from UNHSP to the MA Commission for Deaf and Hard of Hearing.

The MassCARE consumer program completed a survey to identify health education programming for the next year; 39 family members responded.

School-based Health Centers, which serve many CYSHCN, have program standards that address continuity of care, access, consent policies, and parent participation.

The School Health Unit continues to request information on the prevalence of diagnosed health conditions in 638,929 students enrolled in ESHS sites; 29% of the student population has at least one chronic health condition ranging from allergies and asthma to diagnosed depression, autism, etc.

School nurses reported to ESHS providing CYSHCN substantial services at school, including, per month, about 10,779 scheduled (vs. "as needed") doses of medication and almost 179,000 SHN-related treatments or procedures (highest being blood glucose testing, delivered at a rate of 76.2 procedures per month per 1,000 students). These figures underestimate some services, notably for asthma, for which nurses gave nearly 11,400 scheduled and "as needed" doses per month of prescription medications, and for conditions requiring epinephrine, which nurses administered an average of 35 times per month "as needed."

With the assistance of allergists from CHMC and MGH, the School Health Unit revised its data collection forms for the administration of epinephrine in the schools---and vastly expanded the information collected. The comprehensive MA program to prevent deaths due to anaphylaxis in the schools generated interest from parents, providers, and pharmaceutical companies.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. All DPECSHN programs support families to more easily access resources, develop external collaborations for this purpose, and assess barriers in conjunction with consumers, parents, and providers. Telephonic interpreters and TTY are available. | | X | | X |
| 2. Family Initiatives (FI) programs (Family TIES and EIPLP) provide information, support families and partner with community-based services and health care organizations to improve access. | | X | | X |
| 3. The Community Resource Program provides I&R and technical assistance to families and providers using its 800# and, through this centralized service, coordinates access to multiple CYSHCN programs for CYSHCN and their families. | | X | | X |
| 4. DPH Care Coordinators are based in several large pediatric primary care practices across the state with additional Care Coordinators in regional offices serving CYSHCN who are outside the designated practices. | | X | | X |
| 5. Disseminate printed and electronic resources (e.g., Family TIES directory, Directions) and increase resources in multiple languages (e.g., Spanish and Portuguese sections of directory and 2 articles in Spanish in each issue of the EIPLP newsletter). | | X | | X |

| | | | | |
|--|--|---|--|---|
| 6. Technical assistance to families and schools, in particular through MASSTART, allows medically complex CYSHCN to attend public school. | | | | X |
| 7. MassCARE offers a community-based system of care for infants, children, and adolescents with HIV and their families to enable families to access care from local providers and not only major pediatric hospitals. | | X | | X |
| 8. FI and other DPECSHN programs conduct periodic focus groups and surveys to gather current information from parents about barriers and facilitators of access. | | | | X |
| 9. DPH Care Coordinators facilitate regional trainings on benefits and services for CYSHCN for parents and providers. | | | | X |
| 10. On-going participation on internal DPH groups including, EMSC Advisory Board, UNHS and Birth Defects Advisory Committees to share the perspectives of families of CYSHCN and ensure that systems of care incorporate these perspectives. | | | | X |

b. Current Activities

See also Summary Sheet and NPMs #1, 2, 3, 4, 6, and 12.

BFHN supported the production and dissemination of 2500 copies of "Directory of Resources for Families of Children & Youth with Special Needs." The 15th edition contains many new Spanish and Portuguese resources.

On-going collaboration with MA Family-to-Family Health Information Center - DFI serves on the Advisory Board of the Project and presented about Title V at the F2F annual conference.

Family TIES staff continues to build relationships with CBOs serving diverse cultural and linguistic populations to share information about resources and systems of care for CYSHCN.

MassCARE implemented a new service model, based on a strategic planning process, and 5 community sites (three new) were awarded contracts.

School wellness committee regulations will be implemented in August. Five wellness forums were held across the state to assist multi-disciplinary teams to implement the DESE regulations. Many of the panel presenters were from ESHS schools.

At the request of the MGH Home Base Program and the Red Sox Foundation, the SHU and the Northeastern U. School Health Institute held two conferences for 180 school personnel to begin to address the needs of the 13,000 MA students with parents in the military. Collaborators included the Lieutenant Governor and the Office of Veterans' Affairs, among others. The Homebase Program, with SHU input, developed a poster and toolkit to assist school nurses in helping children in military families.

c. Plan for the Coming Year

See also NPMs #1, 2, 3, 4, 6, and 12. Continue ongoing activities.

Identification of new opportunities for regional OFI staff to present to their colleagues within the BFHN and other DPH programs that will increase their knowledge of and commitment to family engagement.

Develop new opportunities for family involvement in community-based pediatric practices.

Expand learning and knowledge-sharing opportunities for EI Parent Contacts about systems of care for families whose children have special health needs so that they can share this knowledge with other enrolled families and in the community.

Increase number of Family Advisors and continue to identify roles and opportunities for them.

Ensure family/consumer input into all CYSHCN Program activities, initiatives and materials.

Continue to identify underserved groups whose children have special health needs and develop effective, appropriate outreach strategies including translation, relationship building and training opportunities.

Continue to promote the spread of Medical Home activities internally and in collaboration with other state, community and health care organizations to promote the spread of Medical Home emphasizing family engagement and ease of access.

Continue participation as needed in EOHHS activities looking at responsive systems of care for families whose children have special health needs and support efforts to strengthen a more integrated and coordinated system of services.

Continue focus on and seek additional resources to develop programs and supports for families of CYSHCN during extraordinary life events and transitions.

Continue to increase awareness of the CYSHCN Program by distributing materials, creating social networking sites and presenting at conferences and community events. Continue broad distribution of CYSHCN Program brochures (in English, Spanish and Portuguese) and promote the Community Support Line as the place to call for assistance.

Outreach to families to become part of an external constituency database for the CYSHCN Program to receive information and identify involvement opportunities. Outreach also to providers and others with an interest in improving systems of care for CYSHCN and their families.

An intern from MGH will assist the SHU in reviewing the expanded dataset for epinephrine administration in the schools.

Another Home Base conference to address the needs of students with families in the military is planned for the fall in the Southeast.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 15 | 46.6 | 47 | 48 | 49 |
| Annual Indicator | 46.6 | 46.6 | 46.6 | 46.6 | 46.6 |
| Numerator | | | | | |

| | | | | | |
|--|-------------|--|--|--|--|
| Denominator | | | | | |
| Data Source | | NS-CSHCN, 2005-2006 (part of NCHS/SLAITS) | NS-CSHCN, 2005-2006 (part of NCHS/SLAITS) | NS-CSHCN, 2009-2010 (part of NCHS/SLAITS) | NS-CSHCN, 2009-2010 (part of NCHS/SLAITS) |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 46.6 | 47 | 47 | 48 | 48 |

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Massachusetts has not improved as we had hoped since 2006. We have adjusted our projections using the latest survey data as a new baseline. The Massachusetts rate is higher than the U.S. rate of 40.0% but not significantly so. Like the rest of the country, there has been no improvement in this measure in the five years. Improving transitions to adulthood - and the adult health care system – especially for CYSHCN remains both a challenge and a priority for MDPH.

Notes - 2010

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001

CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2009

There are no updated state-level data for 2009. Data are from the National Survey of Children with Special Health Care Needs (NS-CSHCN), 2005-2006 conducted as part of NCHS/SLAITS. The 95% Confidence Interval (CI) for the 2005-2006 for Massachusetts was 39.8-53.4; for the nation, it was 40.0-42.5 (point estimate 41.2). The CI's overlap, indicating no statistical difference between Massachusetts and the nation.

a. Last Year's Accomplishments

MassCARE held a workshop for youth and their caregivers (13 participants) to provide feedback to the program. Based on the information gathered from the workshop, trainings were delivered to youth, caregivers and providers around health transition issues.

Community Support Line staff provided information and materials to parents about health transition. Community Resource Program Manager provided 7 trainings on transition for 58 providers and 38 families including one specifically for 20 Spanish-speaking families.

The SSI/Public Benefits Coordinator provided information and referral resources and training for agencies serving transitional youth. She participated on the state Advisory Council for Special Education and the Special Education Steering Committee regarding Federal compliance issues, which monitors and addresses issues regarding transition planning for students to post-secondary education or work.

DPH Care Coordination program revised its standards on transition and developed new materials to assist families and youth in planning for health care transition.

Family TIES worked with a young adult PCA to update "Ladder of Success" Transition Training for YSHCN and had 16 requests for information and support from parents of youth 16-24 years old around transitioning to the adult health care system and growing self-management skills.

Family TIES Director showed and recruited speakers from MRC and Easter Seals to facilitate discussion of a video "Shooting Beauty" which documents the transition experiences of young adults participating in a day program at United Cerebral Palsy Metro Boston with families.

The Health and Disability Unit (HADU) developed a link from the state web site (Mass in Motion) to the National Center on Physical Activity and Disability (NCPAD).

DPH Sexual Assault Prevention and Survivor Services (SAPSS) partnered with Dept of Developmental Services (DDS), Disabled Persons Protection Commission (DPPC) and MA Advocates Standing Strong to provide over 30 peer-based abuse prevention and response trainings for adults receiving services from the DDS provider network. (30 funded by DPH with non-MCH CDC funds; another 20+ funded another way)

DPH Family Planning Program, working with the DDS sexuality educators network, developed "Healthy Relationships, Sexuality and Disability: Resource Guide 2011," for youth with disabilities and special health care needs, parents and providers. The resource guide is designed to provide

information and offer a list of supports, services and organizations to help answer questions regarding sexuality for youth with disabilities and special health care needs, in order to promote healthy and safe attitudes and beliefs about sexuality and help youth enjoy healthy and fulfilling lives. [<http://www.mass.gov/eohhs/docs/dph/com-health/prevention/hrhs-sexuality-and-disability-resource-guide.pdf>]

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Promote the concept of “health transition” and DPH as a focal point for health transition. | | | | X |
| 2. Build external linkages and collaborations with agencies and organizations serving youth, including youth with special health care needs, to ensure health-related transition issues are incorporated into other transition planning efforts. | | | | X |
| 3. Include focus on youth with disabilities and chronic conditions in DPH youth initiatives, e.g. school-based health centers, violence prevention, tobacco, health promotion, suicide prevention and healthy weight. | | | | X |
| 4. DPH Care Coordinators work with parents, youth and other agencies to promote smooth health transition, including transition to adult medical care, and maximize youth autonomy in relation to self-management of health. | | X | | X |
| 5. SSI/Public Benefits Coordinator and Community Support Program staff provide resources, technical assistance and training for agencies serving transition-age youth. | | X | | X |
| 6. DPH Care Coordinators, Family Initiatives staff, and Community Support Program staff offer formal and informal training and technical assistance on transition to families and providers (English and Spanish). | | | | X |
| 7. School-Based Health Center (SBHC) programs for teens with chronic health problems and Essential School Health Services (ESHS) nurses foster responsibility and self-care and promote transition activities. | | X | | |
| 8. As part of the state Sexual Violence Prevention Plan, collaborate with the Department of Developmental Services to promote healthy sexuality and relationships for people with developmental disabilities and their service systems. | | | | X |
| 9. MassCARE provides trainings on health care transition for youth with HIV and their providers and caregivers; outcomes are also used to inform service system decisions for MassCARE and for other providers serving this population. | | X | | X |
| 10. | | | | |

b. Current Activities

See Summary Sheet and NPMs #2, 3, 4, and 5, and Priority Need 5.

Care Coordinators share written information about and discuss the health transition process with families of enrolled youth ages 14-22.

The new MassCARE program model includes youth peers at each site who will assist HIV+ youth in transitioning into adult care.

MassCARE implemented transition standards that included a reporting tool to be used by each site.

MassCARE received onsite technical assistance from HRSA on transitioning youth and using peers in the transition process.

MassCARE is publishing their transition guide "Moving on Positively" for youth with HIV, their caregivers and providers. It is available in English and Spanish.

DPH continues to work with DDS and DPPC, convening regular meetings and conference calls (at least quarterly). The agencies are working to create materials as well as opportunities for cross-training, such as joint provider meetings and workshops, to build DDS providers' and DPH rape crisis center and family planning providers' capacity for the promotion of healthy sexuality/relationships among people with developmental disabilities.

DPH Division of Violence and Injury Prevention continues to train DPH CYSHCN Program Community Support staff on responses and resources for families regarding healthy sexuality education and abuse prevention.

c. Plan for the Coming Year

See also NPMs #2, 3, 4, and 5.

Continue activities on Summary Sheet.

Develop and begin to implement a DPH Youth Transition Initiatives Plan for addressing transition of youth with special health care needs and disabilities, with a focus on health transition.

If funding allows, hire or re-assign current staff to oversee DPH Youth Transition Initiatives.

Enlist graduate student intern(s) to identify and/or develop and/or update transition-related resources for families and providers and develop "Transition to Adulthood Resources Page" for DPH web site and promote widely.

Develop formal mechanism for disseminating information from "Got Transition?" (the National Health Care Transition Center) broadly to staff and families.

MassCARE's Peer Leaders will support enrolled youth with health care transition, including accompanying them to initial adult service system visits.

The PPCN will establish a protocol as part of the standards of operation to identify adult services for youth who will 'age out' of the program on their 19th birthday. This protocol will ensure appropriate health services and facilitate continued support of young adults and their families.

The Health and Disability Unit (HADU) will continue to participate in the DPH Wellness Work Group and help identify ways to ensure inclusion of youth with disabilities in the statewide Mass in Motion initiative and in DPH obesity and tobacco related projects, in order to increase the number of youth with disabilities who have access to health promotion opportunities.

SAPSS will continue working with DDS and DPPC on the implementation of healthy sexuality and violence prevention activities focused on persons with disabilities.

For all 34 SBHCs, efforts will be made to develop partnerships and augment access to community-based resources for youth with special health care needs.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 90 | 89 | 84.1 | 88 | 80 |
| Annual Indicator | 88.3 | 82.3 | 81.1 | 79.9 | 83.3 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | CDC, NIS | CDC, NIS | CDC, NIS | CDC, NIS |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 85.4 | 86 | 86 | 88 | 88 |

Notes - 2011

Fully immunized now corresponds to the CDC definition of 4:3:1:3:3:1 (4 or more doses of DTaP, 3 or more of poliovirus, 1 or more of any MMR, 3 or more of any type Hib, 3 or more of HepB, and 1 or more of varicella) by age 19-35 months (age 3). [Note that definition of measure in Detail Sheet differs from the label on the measure which suggests immunization status among children 19-35 months of age. That age range is what we report here.] Our fully immunized rate improved in 2010-11, and Massachusetts now ranks fourth nationally for this sequence.

Special data reports from the NIS on the previous combination of 4:3:1:3:3 without the varicella were also provided the states this year, although CDC no longer reports in their regular published reports on that combination. For the 4:3:1:3:3 sequence, the 2010 Massachusetts rate was 85.4%, which was a rank of third nationally.

Data are from the National Immunization Survey, as reported by the CDC at http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_2011 for the period FY2010-11. Because the percentage rates are generated by the NIP from surveys, no numerators and denominators are presented in Form 11.

Notes - 2010

Fully immunized now corresponds to the CDC definition of 4:3:1:3:3:1 (4 or more doses of DTP, 3 or more of poliovirus, 1 or more of any MMR, 3 or more of Hib, 3 or more of HepB, and 1 or more of varicella) by age 19-35 months (age 3). [Note that definition of measure in Detail Sheet differs from the label on the measure which suggests immunization status among children 19-35 months of age. That age range is what we report here.] CDC no longer reports on the previous combination of 4:3:1:3:3 without the varicella, so we are using this newer combination and have adjusted the previous two year's reported data also.

Data are from the National Immunization Survey, as reported by the CDC at

http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_2010 for the period CY2010. Because the percentage rates are generated by the NIP from surveys, no numerators and denominators are presented in Form 11.

Our fully immunized rate continued to fall slightly in CY2010, while other states improved theirs, so that Massachusetts now ranks seventh nationally. Antigen-specific analyses of the rate are underway. We have adjusted our targets for to coincide with the new 2020 Healthy People target of 80% for the series that includes 1 varicella and 4 PCV.

Notes - 2009

Fully immunized has been adjusted to correspond to the CDC definition of 4:3:1:3:3:1 (4 or more doses of DTP, 3 or more of poliovirus, 1 or more of any MMR, 3 or more of Hib, 3 or more of HepB, and 1 or more of varicella) by age 19-35 months (age 3), as CDC no longer reports the previous series of 4:3:1:3:3. [Note that definition of measure in Detail Sheet differs from the label on the measure which suggests immunization status among children 19-35 months of age. That age range is what we report here.] Data are from the National Immunization Survey, as reported for CY2009 by the CDC at <http://www.cdc.gov/vaccines/stats-surv/nis/data/tables/09/>. Because the percentage rates are generated by the NIP from surveys, no numerators and denominators are presented in Form 11.

Our fully immunized rate slipped slightly in CY2009, although Massachusetts had the highest rate in the country, well above the national average of 69.9%. However, the rate remains below what it was in FY05 and our performance targets remain adjusted.

a. Last Year's Accomplishments

MA improved rates and ranked fifth in the nation in FY11 for the modified series 4:3:1:3:3:1:4 (excluding HIB) for estimated vaccination coverage NIS Q3/2010-Q2/2011 with 80.1%, compared to the national average of 73.1%. The entire data set for that time frame which includes HIB is not available at this time and is anticipated to be posted on-line by the end of March. Massachusetts has been recognized by CDC (NIS Q3/2010-Q2/2011) for being one of the top five states in the following categories: Highest Childhood Immunization Coverage Award 80.1% (4-3-1-3-3-1-4 series excluding HIB), Highest Adolescent Immunization Coverage Award 81.5% (1-Td/Tdap, 1-MCV4, 1-HPV for girls 13-17 yrs), and Adult Immunization Coverage Award 48.5% (influenza).

For the Hep B birth dose, MA improved its rate by 4.4% to 71.7% for estimated vaccination coverage NIS Q3/2010-Q2/2011, above the national average of 66.6%. [The rates for Hep B at birth range from a low of 22.2% to a high of 82.9%]. Provider education targeting providers regarding the importance of the birth Hep B dose will continue.

The MCH Immunization Program (MCH IP) worked closely with the Massachusetts Immunization Program (MIP) in the Bureau of Infectious Disease Prevention, Response & Services in multiple statewide immunization improvement efforts. The MCH IP collaborated with comprehensive primary care provider agencies serving women and their families (typically community health centers) and local home visiting programs. During FY11, immunization assessments were conducted at 17 federally qualified health center sites due for vaccine assessment and chart review; 13 sites met the threshold (80% according to CDC requirements). The reason for four sites not meeting the threshold included missed opportunities.

MIP provided an update on immunizations, and vaccine storage and handling for MD's, nurses and other professionals in the spring 2011 in eight locations with 837 attendees. Three 1-hour webinars were also held with 214 attending. The MCH Immunization In-Services for outreach workers, community health center staff, and BCHAP program staff were offered in four regions in the fall 2011; 184 attended and 134 nurses received continuing education units (CEU). Providing CEU's has a direct impact on attendance. In total, 313 packets were distributed to attendees and mailed out to sites that were unable to attend.

MCH IP ensures immunization information dissemination to MCH program providers, including Early Intervention Partnership Program (EIPP), FOR Families, Essential School Health Services (ESHS), School Based Health Centers (SBHCs), Children with Special Health Care Needs, local community-based programs and health education programs. There were 214 new school nurses oriented by the Northeastern University School Health Institute including an immunization review.

MCH IP also collaborated closely with ESHS and SBHCs to promote immunizations. SBHC's offer primary health care and behavioral health services in a school-located health clinic. The goal of SBHC care is to keep children/teens healthy and prevent them from missing precious time in class. This facilitates students being served who would otherwise not access health care, including immunizations. During 2011, vaccine administration data were reported for 24 SBHCs funded by MDPH. Approximately 2,700 immunizations (excluding influenza) were administered in this setting. Additionally, 1,440 doses of influenza vaccine were allocated by DPH to these funded SBHC's.

In 2011 Massachusetts had 23 confirmed cases of measles, compared with 3 cases in all of 2010. Two cases were in visitors to the US from overseas and another 4 cases were Massachusetts residents that traveled overseas. An additional 4 cases had lab evidence of a strain of measles that has recently been associated with Europe, where they experienced the largest outbreak of measles in over a decade. Two of the cases were under 12 months of age and an additional 7 cases were in children between 12 months and 18 years of age. Three of the 7 children over 12 months of age were unvaccinated due to parental refusal and another was unvaccinated due to a missed appointment. MDPH issued 4 advisories including situational updates and reminding physicians of the importance of maintaining high two-dose MMR vaccination rates in preventing outbreaks and limiting outbreaks when they do occur.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. All Bureau programs that serve families of infants and young children assess for health care access and the child's immunization status. Referrals and assistance are offered to families of children who are not fully immunized. | | X | | X |
| 2. All WIC children receive an immunization assessment at each WIC appointment until the primary series of shots has been completed. | | X | | |
| 3. The MCH Immunization Program (MCH IP) promotes regular immunization assessments in all programs and compliance with immunization schedules. | | | | X |
| 4. BCHAP MCH IP staff work closely with the Massachusetts Immunization Program (MIP) in DPH's Bureau of Infectious Disease Prevention, Response and Services to ensure that programs have regularly updated information. | | | | X |
| 5. EIPP, Fresh Start, FOR Families and MHVI serving high-risk families, promote well-child care, including immunizations, coordinate and facilitate immunization knowledge and tracking. | | X | | X |
| 6. EI programs provide information on immunization to all families and refer when indicated. | | X | | X |
| 7. Child care providers provide information on immunization to all families and refer when indicated. | | | | X |
| 8. MCH IP staff meets routinely to coordinate a plan to address failed immunization assessments during the previous year. | | | | X |
| 9. Immunization-related information is forwarded to the BFHN and BCHAP staff working with family-serving programs and/or | | | | X |

| | | | | |
|---|--|---|--|---|
| children in the community and to federally qualified health centers and program sites, including services for CYSHCN. | | | | |
| 10. interpreters as part of cultural competence when providing outreach and health education. Immunization Vaccine Information Statements (VIS) are available in many different languages at cdc.gov. | | X | | X |

b. Current Activities

The MCH IP Coordinator attends quarterly meetings at the MCAAP (Massachusetts Chapter of the American Academy of Pediatrics) Immunization Initiative meeting.

Multiple Bureau programs address immunization issues. MCH IP regularly sends information to the program directors and staff at the service delivery sites and offers educational in-services. Programs include community health centers, WIC, EI, EIPP, FOR Families, School-Based Health Centers, Essential School Health Services, CYSHCN and health education programs.

MIP has begun implementation of a statewide immunization registry. Eight sites piloted the system using the graphic user interface in 2011, and a pilot for data exchange sites is now commencing.

Massachusetts new school regulations were implemented in the fall 2011. These changes included 2 doses of MMR, 2 doses of Varicella (both required for kindergarten, 7th grade, full-time college freshmen and health science students) and 1 dose of Tdap (for entry into 7th grade, full-time college freshmen and health science students).

A Clinical Measles Alert was issued on February 8, 2012 after the Indiana Department of Health announced that a case of measles had been confirmed in a child who attended pre-game activities at the "Super Bowl Village". Because of potential exposure, the MDPH encouraged healthcare providers in Massachusetts to consider measles in susceptible patients with rash illness who attended the pre-game activities on February 3, 2012.

c. Plan for the Coming Year

Continue close collaboration with the Massachusetts Immunization Program and continue on-going and current activities, including the following:

Continue to improve MA's immunization rates for the 4:3:1:3:3:1:4 series by continuing annual in-services and material distribution to community partners.

Immunization nurses will continue to work with birthing hospitals to promote the importance of the Hep B birth dose for all infants.

Offer technical assistance to sites that fail assessment with training on how to improve immunization rates including educating parents who refuse immunizations.

Participate in the statewide immunization registry (when fully implemented).

Continue to collaborate with WIC to improve communication and coordination between the programs regarding immunizations.

Consider implementing a plan to monitor possible changes in immunization rates based on parental refusal.

Attend the Massachusetts Immunization Action Partnership Conference in October 2012.

Ensure all children in high-need families enrolled in home visiting programs including EIPP, FOR Families, FRESH Start and MHVI receive appropriate immunizations.

The MCH Immunization Program In-Services for outreach workers, community health center staff, and BCHAP program staff will be offered in four regions in the fall 2012

The Massachusetts League of Community Health Centers is working with the community health centers on a medical home initiative and technical assistance implementing electronic medical records. The future implementation of the MA Immunization registry will make the process of tracking immunizations easier and more cost effective for the sites. Pediatric practitioners at community health centers must also implement quality improvement recommendations from MIP, collaborate with the local WIC program in planning mechanisms for same day immunizations, and implement the most up-to-date "Recommended Childhood Immunization Schedule."

The ESHS Program will continue to address surveillance of communicable diseases. These include advisories in collaboration with the State Lab; these updates are sent to the 2100 school nurses on a regular basis. In addition, information on the recommended adult immunizations (for teachers and other staff) is circulated.

A Clinical Advisory concerning Pertussis in Massachusetts was just issued by the Department on July 2nd. Its recommendations will be addressed during FY13. See the Attachment to this section for a copy of the Advisory.

An attachment is included in this section. IVC_NPM07_Plan for the Coming Year

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-------------|---------------------|---------------------|---------------------|---------------------|
| Annual Performance Objective | 11 | 10.5 | 11 | 10 | 9.5 |
| Annual Indicator | 11.5 | 9.9 | 9.6 | 8.3 | 8.3 |
| Numerator | 1543 | 1361 | 1318 | 1136 | |
| Denominator | 134644 | 136965 | 137435 | 136726 | |
| Data Source | | Mass. Vital Records | Mass. Vital Records | Mass. Vital Records | Mass. Vital Records |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 8.3 | 8.2 | 8.2 | 8.2 | 8.1 |

Notes - 2011

2011 birth data are not available. We have estimated the same rate to that for 2010. See 2010 for the most recent actual data and see the Note for 2010 for data sources and other comments.

Notes - 2010

Birth data are from MDPH, Vital Records for calendar year 2010. This is the most recent year of data available.

The 2010 denominator is from the most recent population estimates for Massachusetts, as provided by the MDPH Bureau of Health Information, Statistics, Research and Evaluation. The number of female teens ages 15-17 is roughly estimated at 60% of the standard 5-year age group 15-19. Because the denominator is an estimate from an estimate, we consider the rate to still be "provisional."

Outyear Performance Objectives have been adjusted again, to reflect a leveling off at the rate, particularly in light of the effect of continued budget cuts to teen pregnancy prevention and family planning services.

Notes - 2009

Birth data are from MDPH, Vital Records for calendar year 2009.

The 2009 denominator is from population estimates for Massachusetts, as provided by the MDPH Bureau of Health Information, Statistics, Research and Evaluation. The number of female teens ages 15-17 is roughly estimated at 60% of the standard 5-year age group 15-19.

Outyear Performance Objectives have been adjusted to reflect a leveling off of the rate, particularly in light of the effect of continued budget cuts to teen pregnancy prevention and family planning services.

a. Last Year's Accomplishments

See also SPM #1 and Priority #5 in the Attachment to Section 4F.

15 evidence-based teen pregnancy prevention programs continued to be funded in high teen birth rate communities. All programs are implementing curricula and providing referrals and additional services to youth, their families and their communities. A cross-site evaluation is managed by John Snow Inc. As mandated by state legislation, 168 youth in foster care and/or involved with the Department of Children and Families were served by a teen pregnancy prevention program.

Family planning services funding decreased by another 1.25% in FY11 to \$4.47M, due to state budget cuts. Over the past four years, the number of clients served across all agencies under the age of 20 has decreased at twice the rate of the number of clients over 20, suggesting that these cuts may have disproportionately affected access to family planning clinical care among young people.

The "Where can I get Plan B?" flow chart was updated to reflect the lowered age limit of 17 and remains downloadable on the Clearinghouse website. It provides information about what to do if one has had unprotected sex in the last five days. Action steps are described and MA resources are provided about how to obtain emergency contraception.

Maria Talks (www.mariatalks.com), developed with the DPH Family Planning Program, OAHYD, STD Bureau, DVIP, OHA, and other related MDPH programs, and hosted by AIDS Action Committee (AAC), is the statewide sexual health hotline and website program targeted to adolescents, with the goal of providing accurate health information and referrals to family planning and related services. In FY 11, the website completed a major overhaul that included a transition to a content management system, increased site usability and readability, and added HIV content. A MA Promise Fellow managed a Youth Action Board to get youth feedback and used peer leaders to help promote the site through word-of-mouth, Facebook, and other social

media. These and other marketing efforts helped generate 66,837 visits to the website and 383 phone calls and emails during FY11.

SBHCs in high schools provided extensive health education on topics including contraception, STIs, healthy relationships, & pregnancy prevention education ("Baby think it over"). In two communities with high pregnancy rates, SBHC clinicians worked on core planning teams with the Massachusetts Alliance on Teen Pregnancy to establish an action plan for the Youth First initiative. The goal of this initiative is to reduce the teen birth rate in two cities by 10% within five years through a multi-pronged approach.

In FY11, 39.42% (1598 / 4054) of female clients aged 15 through 17 years who had at least one visit to the SBHC were identified to be at risk for STD/pregnancy. Of those clients, 99.62% had a follow up plan (i.e., received risk reduction counseling), as appropriate. Of the 4,054 female clients aged 15-17 years who had at least one visit to the SBHC, 27.60% had a pregnancy test at least once during FY11.

In conjunction with the annual release of Massachusetts birth data, fact sheets are distributed about teen pregnancy in the communities with the highest teen pregnancy rates and in communities with science-based programs. Communities use the fact sheets to generate media attention and inform local response.

In August 2010, MPDH, in partnership with the MA was awarded \$1,062,646 to support the Personal Responsibility Education Program (PREP). In addition to replication of evidence-based models, PREP will incorporate at least 3 adulthood preparation subjects into teen pregnancy prevention programming among youth populations that are the most high-risk or vulnerable for pregnancies. The Sexuality Education Stakeholders Group, an interdepartmental working group, hosted a Strategic Engagement Forum to gain input from experts in the field of adolescent sexual and reproductive health and youth development to inform the procurement process. OAHYD worked with Massachusetts DESE to establish PREP-funded pilot TPP curricula in select high teen birth rate/low performing school districts. A competitive procurement (RFR) was issued to implement PREP programming in 7 high teen birth rate communities.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Evidence-based teen pregnancy programs are funded in 15 communities with high teen birth rates (components include individualized case management, sex education, HIV/AIDS prevention, and service learning). Independent evaluation and TA are funded. | | X | | X |
| 2. Family Planning (FP) agencies provide clinical and other services to adolescents statewide. An access coordinator and semi-annual statewide Abortion Access Group meetings ensure all teens have access to services. | X | | | X |
| 3. The FP program works with Keep Teens Healthy, a Medicaid program providing family planning outreach to high-risk teens, and with the Office of HIV/AIDS on integration of HIV Counseling and Testing into family planning clinics. | X | X | | X |
| 4. FP continues to implement EC legislation, provide resources to adolescents, and educate adolescent service providers; and with DVIP, BHCQ, and the pharmacy access program to monitor hospital compliance. | | | | X |
| 5. Ongoing dissemination of knowledge about Emergency Contraception and a statewide Sexual Health hotline and | | | | X |

| | | | | |
|--|---|---|---|---|
| website, Maria Talks. | | | | |
| 6. Youth Risk Behavior Survey (YRBS) and Massachusetts Youth Health Survey (YHS) surveillance data help monitor pregnancy risk behaviors and inform work of the Adolescent Health Council (AHC) and Youth and Young Adult Working Group (YYAWG). | | | | X |
| 7. The Office of Adolescent Health and Youth Development (OAHYD) provides leadership for youth development within DPH and coordination for the Governor's Council on Adolescent Health. | | | | X |
| 8. SBHCs provide comprehensive primary care including reproductive health care. | X | | | |
| 9. Most ESHS health education programs include reproductive health and the School Health Manual has a chapter on reproductive health. | | | X | X |
| 10. Interconception counseling including reproductive planning is incorporated into MHVI programs including evidence-based home visiting for first time teen parents. | | X | | |

b. Current Activities

See also SPM #1 and Priority #5 in the Attachment to Section 4F.

PREP contracts in the communities of Boston, Fall River, Worcester, Lawrence, Springfield, Lowell and Holyoke took effect in April 2012.

The SBHC Program is working (via two targeted communities with some of the highest teen pregnancy rates in Massachusetts) with the Massachusetts Alliance on Teen Pregnancy to increase the number of youth using adolescent sexual health services, contraception and condoms. Formal partnerships have been developed between SBHC's and local clinical agencies to develop 'clinic collaboratives' through which protocols have been developed for rapid referrals for contraceptive services).

In preparation for an RFR, the Family Planning Program completed a needs assessment of stakeholders, including an online survey of youth on their needs for reproductive health services. Surveys were distributed both through an online Survey Monkey link and hard copy versions mailed to youth-serving organizations across Massachusetts. Responses were received from a total of 137 females, 164 males, and 7 people of unknown gender. The average age of respondents was 17.3 for females and 16.6 for males.

The new RFR was released. See SPM #1 for more information about the RFR and the new contract goals. To mirror federal health reform, eligibility for confidential clinical services will continue for teens but will expand for young adults, ages 20 to 26, and for survivors of violence.

c. Plan for the Coming Year

See also SPM #1 and Priority #5 in the Attachment to Section 4F.

The OAHYD will continue to offer statewide trainings to Department of Children and Families staff on having discussions with young people on healthy relationships and adolescent sexual health.

OAHYD will continue to partner with Massachusetts DESE in order to support PREP funded TPP curricula delivered in select high teen birth rate/low performing school districts in the Commonwealth. In addition to replication of evidence-based models, PREP will incorporate at least three PREP funding supported state-wide youth services provider trainings; topics included:

Understanding Youth Development, Sexuality and Self-Care for Teens/Contraception and STI/HIV Prevention, Environmental Strategies in Teen Pregnancy Prevention, Working with High Risk Youth Populations, Healthy Relationships and Sexuality Educator Certification, and a mandatory PREP Grantee Getting to Outcomes training,

The SBHC Program will provide training to new vendors including clinical staff (in collaboration with Massachusetts Alliance on Teen Pregnancy) to share best practices that have been identified in the first year of the Youth First initiative. Clinicians will learn from their colleagues in the two Youth First communities about i) evidence-based teen pregnancy prevention programs ii) protocols that were developed with collaborating family planning agencies to address barriers to clinical care (i.e. contraception) in school settings iii) media messages supportive of teen pregnancy prevention that have appeared in the two Youth First communities.

State funding for family planning is expected to remain at FY12 levels. These reductions, compounded by reductions in each of the last four fiscal years, will have significant impacts on the scope of services that the MDPH-funded family planning agencies can provide, including services to adolescents. Technical assistance and training needs of new providers will be assessed and appropriate training provided throughout FY13. Site visits are planned with all new contracted vendors to ensure that needs of and services to adolescents are sufficiently addressed.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 63 | 66.5 | 68 | 65 | 63 |
| Annual Indicator | 66.2 | 67.4 | 63 | 62.5 | 66.6 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | Mass. BRFSS | Mass. BRFSS | Mass. BRFSS | Mass. BRFSS |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 67 | 68 | 68 | 69 | 69 |

Notes - 2011

The data for 2011 are taken from the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS). A children's dental health module, containing this and other questions, is carried out every year. The data are not specific for the narrow age range specified in the measure, but capture data for children ages 6 - 17. The estimated percentage improved in the 2011 survey, with a 95% Confidence Interval of 60.4% to 72.8%, indicating that the rate may not be statistically different from 2010. However, projections through 2016 have been adjusted.

Notes - 2010

The data for 2010 are taken from the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS). A children's dental health module, containing this and other questions, is carried out every year. The data are not specific for the narrow age range specified in the measure, but capture data for children ages 6 - 17. The estimated percentage remained virtually unchanged in the 2009 survey, and the 95% Confidence Interval of 57.4% to 67.5% indicates that the rate remains not statistically different from 2009.

Notes - 2009

The data for 2009 are taken from the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS). A children's dental health module, containing this and other questions, is carried out every year. The data are not specific for the narrow age range specified in the measure, but capture data for children ages 6 - 18. The estimated percentage fell in the 2009 survey, but the 95% Confidence Interval of 57.9% to 68.1% indicates that the rate remains not statistically different from the previous year.

a. Last Year's Accomplishments

For FY11, MassHealth (Medicaid) reported that a little more than 30% of their members 6-9 years of age received a dental sealant, which is about the same from the previous fiscal year.

The state also measures the number of 6-17 year olds with at least one dental sealant using the annual BRFSS. According to 2009 data, 63.0% of children reported on had at least one dental sealant (a rate that is not statistically different from the previous year). Note that this rate is not for the exact age group specified in the measure. Survey results show consistently higher rates of sealants as parent education levels rise.

The data is limiting in that it does not single out 3rd graders (8-9 year old children) from other age groups. At this time, the Office of Oral Health (OOH) cannot track all 3rd grade students in the state, but has developed a monitoring form by working with Essential School Health Services (ESHS) and relying on the school nurses to report on the numbers of children served by the programs that enter their schools.

Due to fee increases in the MassHealth dental program, the latest in 2009, the reimbursement rate for dental sealants was increased. Thus, the number of programs providing this service in school-based and school-linked preventive dental programs has increased, as well.

Historically, school-based programs have served children who would not otherwise receive these services in a private practice. Third grade children covered by MassHealth and CMSP, as well as others with no insurance, are increasingly able to access preventive dental procedures, such as sealants through these mobile and portable programs. The percentage of MassHealth eligible children receiving dental sealants in the two most age appropriate groups -- 6-9 and 10-14 -- range from 32-38%, with a slight decrease in the 10-14 year old group in FY10.

The OOH first implemented its school-based sealant program in 2006 with funding from HRSA. Subsequent funding from both HRSA's BHP and MCHB have allowed the program to expand from one school in one high-need community to 133 schools in 13 high-need communities. The program is available to more than 10,000 school-age children and places more than 10,000 dental sealants annually.

The OOH and the School-based Health Center Unit (SBHC) established a strong partnership early, and the OOH sealant program provides services in 17 SBHCs statewide. About 2,000 dental sealants were provided to this population, and more than 80% of the students participating are Medicaid-eligible.

In school year 2010-2011, 65% of all public schools with at least 50% participation in the free and reduced school lunch program hosted a dental sealant program; with 80% participation by elementary schools statewide.

School nurses continue to perform more oral health related activities. The ESHS data tracks the percentage and numbers of children provided oral health screenings, whether screenings were performed by nurses, dentists or hygienists; third grade screenings; dental sealants; fluoride rinses; and referrals to the dental provider. The typical district participating in oral health screening activities screened students at an annual rate of 50.0 per 1,000 students, an increase from 45.4 in 2010. There was considerable variability across districts, with the range being 0.2 to 497.0 screenings per 1,000 students. Slightly more than one-third of oral health screenings were performed by school nurses.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. MassHealth, CMSP and most other 3rd party payer dental benefits include protective sealants for children. | X | | | |
| 2. Outreach and improved reimbursement rates for the MassHealth/CMSP dental provider network using the state's Third Party Administrator, DentaQuest. | | | | X |
| 3. The Office of Oral Health (OOH) provides leadership to improve oral health status with a focus on children and preventive services. | | | | X |
| 4. OOH conducts surveillance of 3rd grade children's oral health status, including sealants and provides technical assistance to schools, community programs and community health centers interested in developing sealant programs. | | | X | X |
| 5. School-based preventive (sealant) programs are statewide, including all public elementary schools in Boston. OOH also provides direct service delivery of dental sealants in state-funded SBHCs. | X | | | X |
| 6. The OOH collaborates with ESHS and school nurses re programs and services and provides oral health training to school nurses in ESHS-funded districts; the revised school health manual includes an oral health chapter. | | | | X |
| 7. Dental services provided in community health centers and other contracted primary care sites. The OOH collaborates with many CHC dental programs to develop sustainability within programs and access to restorative treatment. | X | | | |
| 8. Specialist oral health consultant promotes preventive dentistry services for CSHCN. | X | | X | X |
| 9. Expansion of school-based programs to 7th graders to measure against Healthy People 2010 Objective 21-8(b). | X | | | |
| 10. Weekly school fluoride mouth rinse program serves approximately 50,000 children annually. | X | | | |

b. Current Activities

See also ongoing activities Summary Sheet above.

In school year 2011-2012, the OOH expanded its school-based oral health prevention program to 13 high-need communities, serving grades K-12 in 133 schools. Over 80% of the children with consent are MassHealth eligible. Direct reimbursement to the Office of Oral Health by MassHealth for the sealants and fluoride sustains the program and its personnel. Plans include expanding the program to at least three additional high-need communities in school year 2012-

13. Data from the program is managed and analyzed using the CDC's SEALs program, and the program has demonstrated a 93% retention rate for the sealants placed.

In June 2011, the Office of Oral Health hosted a school-based oral health program provider meeting. About 75 dental professionals and stakeholders attended the meeting, where information was provided by school nurses, the Department of Elementary and Secondary Education and the Board of Registration in Dentistry. In addition, a presentation was offered on infection control for mobile and portable oral health programs.

c. Plan for the Coming Year

Current activities will continue.

In FY 2013 (September 2012), the OOH will be expanding its school-based sealant programs serving elementary, middle school and high school students.

Since its inception in 2006, the SEAL Program has been supported with funding from MCHB and HRSA. Beginning in 2011, it became self-sustaining through MassHealth reimbursement.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-------------|---------------------|---------------------|---------------------|---------------------|
| Annual Performance Objective | 1.2 | 1.2 | 1.2 | 0.7 | 0.7 |
| Annual Indicator | 0.8 | 0.7 | 0.5 | 0.5 | 0.5 |
| Numerator | 9 | 8 | 6 | 6 | |
| Denominator | 1188128 | 1148340 | 1145024 | 1141903 | |
| Data Source | | Mass. Vital Records | Mass. Vital Records | Mass. Vital Records | Mass. Vital Records |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 |

Notes - 2011

2011 death data are not available. See 2010 for the most recent preliminary data and see the Note for 2010 for data sources and other comments. We have estimated a rate in line with the 2010 rate.

Notes - 2010

Data on deaths are taken from MDPH Vital Records for calendar years 2008 - 2010. This includes the most recent year of data available. 2010 data are still preliminary and subject to change in the final file. Rates are calculated as rolling 3-year averages. (I.e. the 2010 numerator is the sum of the 2008, 2009 and 2010 numbers of deaths (6, 8, and 4) respectively and the denominator is the sum of the most recent Massachusetts population estimates for the age group for the same years.

The denominator is from the most recent population estimates for Massachusetts, as provided by the MDPH Bureau of Health Information, Statistics, Research and Evaluation. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere.

Notes - 2009

Data on deaths are taken from MDPH Vital Records for calendar years 2007 - 2009. Rates are calculated as rolling 3-year averages. (I.e. the 2009 numerator is the sum of the 2007, 2008 and 2009 numbers of deaths (5, 6, and 8) respectively and the denominator is the sum of the most recent Massachusetts population estimates for the age group for the same years.

The denominator is from the most recent population estimates for Massachusetts, as provided by the MDPH Bureau of Health Information, Statistics, Research and Evaluation. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere.

a. Last Year's Accomplishments

See also SPM # 08 and Priority Need #7 in the Attachment to Section IV.

Staff of the Injury Prevention and Control Program (IPCP) within the Division of Violence and Injury Prevention

(DVIP) continued to focus on Child Passenger Safety issues. Activities included:

- Coordination with MassPINN (Massachusetts Prevent Injuries Now Network) and the Partnership for Passenger Safety on proposed policy issues. Working in such partnerships, work continued on providing technical assistance to partners in the passage of a primary seat belt law. (Studies show that increasing restraint use for adults contributes to appropriate restraint use for children.)
- Technical support, referrals and education materials to the public via the Car-Safe Phone Line (note that mid-year, DPH coordinated with the Executive Office of Public Safety Highway Safety Division in a decision to consolidate the DPH Car-Safe Phone line with that operated by Highway Safety -- so there is now a single child passenger safety help line answered by Highway Safety. Members of the public who call the old DPH number are referred to the HSD's phone line.)
- Facilitation of quarterly meetings of the Partnership for Passenger Safety (PPS), including working groups focused on child passenger safety and teen driving safety.
- Attendance at meetings and technical support to coalitions and partners such as Greater Boston Safe Kids Coalition, Western MA Safe Kids Coalition, AAA of Southern New England, American Association of Pediatrics, Brain Injury Association of Massachusetts, and Boston Medical Center.
- Participation in the ongoing development of Executive Office of Transportation's Massachusetts Strategic Highway Safety Plan.
- In preliminary work on the development of a new five year Injury Prevention Strategic

Plan undertaken by the IPCP, Childhood Injury and Transportation Injury were both identified as priority areas of focus. It is anticipated that these will include a continued focus on child passenger safety and teen driving safety as the Strategic Plan is further developed.

EIPP and other Home Visitors provided information to parents on infant passenger safety and resources to obtain child safety seats with instructions for their proper use.

SBHC standards recommend that all SBHC-enrolled enrolled students receive an annual risk and resiliency assessment that includes screening for seatbelt use. SBHC clinicians continued to screen students, including those under 15, who had at least one visit to the SBHC for "seatbelt non-use". Students identified as "at-risk" are required to have a follow up plan that includes risk reduction counseling and/or anticipatory guidance.

SBHC clinicians are also using the CRAFFT tool for substance use assessment; the first item on the screening tool asks "Have you ever ridden in a CAR driven by someone including yourself who was "high" or had been using alcohol or drugs?" This is a validated question intended to assess for risk of vehicular homicide. The SBHC Program collaborated with the Institute for Health and Recovery (IHR) to provide CRAFFT and SBIRT (screening, brief intervention, referral and treatment) training to SBHC providers. IHR staff provided on-site training to each SBHC site. Local substance abuse service providers in the SBHC communities attended these on-site training sessions in order to improve referral mechanisms for students at risk.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Child Fatality Review Teams operate in every county; MDPH participates on both local and state Teams and IPCP responds to Child Fatality Review Annual Report recommendations re issues of child passenger safety and bike/pedestrian safety. | | | | X |
| 2. IPCP sits on the Educational Committee with staff of DCR and other partners to implement the ATV legislation. | | | | X |
| 3. IPCP disseminates educational materials on child passenger safety (CPS) to relevant MDPH programs, consumers, and providers. | | | X | X |
| 4. . IPCP coordinates with coalitions, such as the Greater Boston Safe Kids Coalition, Western Mass. Safe Kids Coalition, Injury Free Coalition for Kids of Boston, and MassPINN. | | | X | X |
| 5. IPCP also coordinates with such organizations as AAA of Southern New England, American Academy of Pediatrics, Brain Injury Association of Massachusetts, and Boston Medical Center, including work/advisory groups. | | | X | X |
| 6. IPCP implements traffic safety objectives included in the 5- | | | | X |

| | | | | |
|---|--|---|---|---|
| year injury prevention strategic plan and statewide highway safety plan. | | | | |
| 7. IPCP continues to distribute passenger safety related materials and improve collaboration/integration of CPS information and materials with state and other agencies serving children. | | | X | X |
| 8. EI, EIPP, FRESH Start, FOR Families, ESHS, MIECHV, WIC, and SBHCs provide education to clients on passenger/ motor safety and on resources for obtaining child safety seats. | | X | | X |
| 9. IPCP facilitates Partnership for Passenger Safety meetings. | | | | X |
| 10. | | | | |

b. Current Activities

The Injury Prevention and Control Program continued their ongoing work in child passenger safety including those listed in Summary Sheet.

Additionally, work continues on the development of the new five year Injury Prevention Strategic Plan and the two related priority areas -- Childhood Injury Prevention and Transportation Safety. As the plan has been more fully developed, specific focus areas and SMART objectives aimed at improving passenger restraint (through a primary seat belt law) have emerged. A focus on increasing passenger restraint in adults has been shown to improve appropriate child passenger restraint usage.

c. Plan for the Coming Year

The Injury Prevention and Control Program plans a number of targeted activities to reduce motor vehicle deaths

amongst this age group:

- Increase parental knowledge and enforcement of Graduated Driver's License (GDL) policies.
- Lead the implementation of activities identified in the new Injury Prevention Strategic Plan that focus on increasing seat belt usage rate including continuing to coordinate with MassPINN and the Partnership for Passenger Safety on providing technical assistance to our partners to focus on the passage of a primary seat belt law.
- Develop an MDPH safe driving policy for all Department employees operating a motor vehicle while working.
- Facilitate quarterly meetings of the Partnership for Passenger Safety (PPS) and its working groups.
- Continue to attend meetings and provide technical support to coalitions, such as Greater Boston Safe Kids Coalition, Western MA Safe Kids Coalition, AAA of Southern New England, American Academy of Pediatrics, and Brain Injury Association of Massachusetts.
- Serve as founding board members of the new Massachusetts Safe Kids, coordinated by the Children's Hospital.
- Participate in meetings of the Executive Office of Transportation's Massachusetts Strategic Highway Safety Plan and participate in the development of action plans for appropriate recommendations.

SBHCs will continue to promote the consistent use of CRAFFT screening across all SBHCs. The SBHC program will continue to analyze aggregate data to determine the prevalence of risk assessment in this category.

EIPP, FRESH Start, FOR Families, MHVI and other Home Visitors will continue to provide information to parents on infant passenger safety and resources to obtain child safety seats with instructions for their proper use. MHVI will collect and analyze data on visits for children 0 -- 5 years to emergency departments to assess efficacy of injury prevention education and support.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | 45 | 42 | 45 | 50.2 | 50.5 |
| Annual Indicator | 47 | 44.2 | 46 | 56.8 | 56.8 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | CDC, NIS | CDC, NIS | CDC, NIS | CDC, NIS |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 56.8 | 57 | 58 | 59 | 60 |

Notes - 2011

Data Source: The CDC National Immunization Survey data for the 2010 birth cohort have not been released. We have estimated a similar rate to that of the 2009 birth cohort. We have modified our outyear projections as well.

The 2011 PedNSS report will be the last produced by the CDC, as both the PedNSS and PNSS data systems are being discontinued. In the 2011 PedNSS report, breastfeeding at 6 months for WIC clients was 27.6%, a slight improvement from the 2010 PedNSS data.

Massachusetts WIC data for October – December 2011 shows a statewide breastfeeding initiation rate of 76%, a 3 month duration rate of 40% and a 6 month duration rate of 30%.

Notes - 2010

CDC Breastfeeding Report Card 2012 (data from the National Immunization Survey for the 2009 birth cohort. Released in August, 2012. Because they are survey data, there are no numerator or

denominator values.

2010 Massachusetts PedNSS data about breastfeeding among WIC participants are also available. The initiated breastfeeding rate was 73.8%, unchanged, and the rate at 6 months was 25.2%, down from the previous 3 years.

Massachusetts 2010 birth certificate data on breastfeeding (or intent to breastfeed) at hospital discharge indicated a rate of 82.9%, a slight increase from 2009.

2009 Massachusetts PRAMS data showed that 84.1% of respondents reported any breastfeeding (comparable to the birth certificate data), and above the HP 2020 Target of 75%. 71.7% reported any breastfeeding (exclusive or with complementary foods) for at least 4 weeks and 62.4% for at least 8 weeks. About 46.9% reported exclusive breastfeeding for at least 4 weeks (a decrease from the last PRAMS report) and about 38.3% for exclusive breastfeeding for at least 8 weeks.

Notes - 2009

Data Source: CDC Breastfeeding Report Card 2011 (data from the National Immunization Survey for the 2008 birth cohort).

Massachusetts 2009 birth certificate data on breastfeeding (or intent to breastfeed) at hospital discharge indicated a rate of 82.0 %, up from from the 2008 rate of 80.8%.

Massachusetts 2009 birth certificate data on breastfeeding (or intent to breastfeed) at hospital discharge indicated a rate of 82%, up again from 2008; the rate increased among all mothers and across all racial groups.

2007/2008 Massachusetts PRAMS data showed that 81.6% of respondents reported any breastfeeding (comparable to the birth certificate data). 70.6% reported any breastfeeding (exclusive or with complementary foods) for at least 4 weeks and 62.2% for at least 8 weeks. About 55% reported exclusive breastfeeding for at least 4 weeks and about 47% for exclusive breastfeeding for at least 8 weeks.

a. Last Year's Accomplishments

According to the 2010 CDC PedNSS Report, 73.8% of WIC infants were breastfed in 2010, unchanged from 2009 and compared to 62% nationally in 2008. The breastfeeding rate at 6 months was 25.2%, down from the previous 3 years. The decrease likely reflects the implementation of the new WIC food package. There were some decreases in overall breastfeeding but improvements in exclusivity. There were also some used data errors due to the new food package rules that have since been fixed. We are eager to see 2011 data to see what trends are developing.

Data released in August 2011 from the 2008 CDC National Immunization Survey birth cohort, which includes participants from a more diverse socioeconomic background, shows a higher percentage of infants breastfeeding at 6 months in Massachusetts (46.0%) compared to national rates (44.3%).

WIC provided breastfeeding peer counselor services to all 35 WIC Programs, with more than 100 peer counselors statewide. WIC offered "Breastfeeding Basics" training and advanced breastfeeding in-services to WIC nutrition staff and other interested staff of related programs.

The Nutrition Division, in partnership with perinatal programs within the Bureau, continued to support the Guidelines for Breastfeeding Initiation and Support with birth hospitals in Massachusetts. DPH Breastfeeding Achievement Awards were given to hospitals that are taking steps to improve their environments and policies by applying for Certificates of Intent with the Baby Friendly Hospital Initiative.

The Nutrition Division continued to distribute the breastfeeding brochure "You've Got What It Takes...Give Your Baby the Best" in multiple languages to birth hospitals.

DPH was an active member of the Massachusetts Breastfeeding Coalition (MBC).

WIC continued to implement a statewide Breastfeeding Performance Improvement Project to improve breastfeeding initiation and duration rates as well as to improve the efficacy of the peer counselor program.

WIC launched a Breastfeeding Social Marketing project via radio, print and transit advertising to improve breastfeeding promotion partnerships with the health care provider community and to increase awareness of WIC's breastfeeding resource for families.

In FY11, 57% of all EIPP Participants were breastfeeding at birth with 38.15% breastfeeding exclusively. At 2 weeks post partum, 50% of EIPP Participants continued to breastfeed while 23.48% were breastfeeding exclusively. Only 15% continued to breastfeed at six months post partum. Barriers for mothers continuing to breastfeed include domestic violence, maternal depression, easy access to infant formula, lack of support at place of employment or school, mothers being prescribed psychotropic medications and breast-related problems.

Since revised perinatal regulations were promulgated in 2006, the BFHN and the Bureau for Health Care Safety and Quality (BHCSQ) have been collaborating on a system of reviewing services in each birth hospital to determine an appropriate level designation. Level III hospitals and those with an identified concern for the standard of care being provided were prioritized for on-site surveys by BFHN/BHCSQ staff. 45 of 47 active Massachusetts Birth Hospitals and the Boston Children's Hospital NICU had been surveyed and re-designated. In addition, we have also surveyed (just recently) one of two Birth Centers.

As part of the survey process, MDPH staff review compliance with regulations that support initiating breast feeding; provide the updated Massachusetts Breastfeeding Resource Guide; and offer information about training hospital staff on how to best support breastfeeding mothers.

BFHN staff collaborated with Vital Statistics to support training activities related to the new question on exclusive breastfeeding at discharge on the electronic birth certificate.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. The Breastfeeding Coordinator provides active leadership to promote breastfeeding statewide, and multifaceted approaches reach health care professionals, parents/extended family, and general public. | | | | X |
| 2. The Nutrition Division produces and disseminates educational materials and provides basic and advanced training to professional and paraprofessional staff in WIC and other DPH programs to promote breastfeeding. | | | | X |
| 3. Guidelines for Promoting and Supporting Breastfeeding are updated and promoted through all hospital maternity units; BFHN and HCQ joint hospital perinatal licensure visits review hospitals' compliance with breastfeeding regulations. | | | | X |
| 4. Local WIC programs encourage and counsel all women on breastfeeding benefits, provide manual pumps, refer, offer classes and support groups in multiple languages, and establish | | X | | |

| | | | | |
|---|--|---|--|---|
| goals re breastfeeding initiation rates for women enrolled prenatally. | | | | |
| 5. All local WIC programs provide breastfeeding peer counseling services, and local offices offer community-wide celebrations of World Breastfeeding Week to increase awareness and support. | | X | | X |
| 6. WIC and community health center nutritionists actively cross-refer, including health centers referring to peer counselors, based on standing agreements between local organizations required of all local WIC offices. | | X | | X |
| 7. The Nutrition Division is active in the Massachusetts Breastfeeding Coalition and annually distributes the MA Breastfeeding Resource Guide and other educational materials to birth hospitals, physicians and other health professionals. | | | | X |
| 8. EIPP and MHVI provide intensive breastfeeding support and coordinate with WIC to improve initiation and duration rates and referrals to advanced lactation support; EIPP and MHVI collect and manage related data to inform program development. | | X | | X |
| 9. Annually, the Partners in Perinatal Health Conference updates MA perinatal providers about breastfeeding topics. | | | | X |
| 10. Through PNSS, PedNSS, other WIC resources, PRAMS, and EIPP, Massachusetts collects, evaluates and disseminates data related to breastfeeding initiation, duration and exclusivity. | | | | X |

b. Current Activities

DPH recognized hospitals that have made attempts to improve breastfeeding care by convening breastfeeding task forces or committees. DPH also collaborated with the MA Breastfeeding Coalition to encourage birth hospitals to become "bag free" and not directly market formula to new parents. Research has shown that parents who receive bags with items that promote formula are less likely to continue breast feeding past the first month postpartum. As of 7/1/2012, all birth hospitals will be bag free, and MA will be the second state in the country to ban formula company sponsored bags for new parents. [Rhode Island was the first.]

The Nutrition Division and WIC continue to enhance hospital collaboration with community-based programs such as WIC's Peer Counselor Program. Local WIC programs are increasing face-to-face contact with health professionals.

WIC continues to implement a statewide Breastfeeding Performance Improvement Project to improve initiation and duration rates and to improve the efficacy of the peer counselor program.

WIC launched a second phase of the Breastfeeding Social Marketing project via television and radio ads to increase awareness of WIC as a breastfeeding resource.

A question regarding exclusive breastfeeding at hospital discharge is now on the electronic birth certificate.

EIPP and MHVI home visiting staff receive training in supporting new parents to breastfeed for as long as possible and recommending exclusive breastfeeding for the first 6 months of life.

c. Plan for the Coming Year

Continue ongoing activities.

The Nutrition Division, in partnership with perinatal programs within the Bureau, will update and re-release the Guidelines for Breastfeeding Initiation and Support with birth hospitals in

Massachusetts. The Guidelines provide hospital staff with rationale and implementation guidance for the breastfeeding components of the perinatal licensure regulations, as well as outline best practices for breastfeeding support that further enhance the required policies and procedures. DPH Breastfeeding Achievement Awards will be given to hospitals that are taking steps to improve their environments and policies related to breastfeeding care.

In collaboration with BCHAP, BFHN staff plan and deliver training and related resources to hospitals in an effort to support movement towards the Baby Friendly Hospital Initiative.

Since completing the survey of hospitals, MDPH will continue to review protocols and offer training for breastfeeding, MDPH will continue to encourage active participation in the CDC mPINC survey (maternity Practices in Infant Nutrition and Care). The mPINC is a biannual national census of facilities that is designed to allow data to be used for advocacy and policy development to influence practice at facility and state levels.

BFHN staff will collaborate with Vital Statistics to provide reports to hospitals on rates of exclusive breastfeeding at discharge collected from the electronic birth certificate.

EIPP and MHVI home visiting staff will receive updated training on breast feeding support for all new mothers. MHVI plans to incorporate nurses as a home visiting component specifically to provide breast feeding support to women giving birth in high need communities.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-------------|---|---|---|---|
| Annual Performance Objective | 99.8 | 98.8 | 98.8 | 99 | 99.2 |
| Annual Indicator | 98.8 | 99.1 | 98.7 | 99.2 | 99.4 |
| Numerator | 77762 | 76817 | 74957 | 72698 | |
| Denominator | 78724 | 77546 | 75916 | 73280 | |
| Data Source | | Vital Records & Child Hearing Data System | Vital Records & Child Hearing Data System | Vital Records & Child Hearing Data System | Vital Records & Child Hearing Data System |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or | | | | Final | Provisional |

| | | | | | |
|------------------------------|-------------|-------------|-------------|-------------|-------------|
| Final? | | | | | |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 99.4 | 99.6 | 99.6 | 99.6 | 99.6 |

Notes - 2011

Neither preliminary nor final CY 2011 data are not yet available. We estimate a similar rate to the CY2010 rate.

Notes - 2010

Pre-discharge screening rates as tracked by the Childhood Hearing Data System (CHDS). The numerator and denominator have been updated based on final, "clean" screening data and the closed 2010 birth file.

Screening rates are slightly less than 100% and will remain so due to a small number of parents who refuse the screening, infants who died prior to screening (258 in 2010), and unknown/missed screens. The majority of those not screened are unknown or missed screens, including those missed due to transfers.

Our goal – which is reflected in our performance objectives through 2016 -- is to continue to reduce the unknown/missed number to close to zero, leaving only refusals and deaths prior to screening as unscreened.

Notes - 2009

Pre-discharge screening rates as tracked by the Childhood Hearing Data System (CHDS). The numerator and denominator have been updated based on final, "clean" screening data and the closed 2009 birth file.

Screening rates are slightly less than 100% and will remain so due to a small number of parents who refuse the screening, infants who died prior to screening, and unknown/missed screens. The majority of those not screened are unknown or missed screens, including those missed due to transfers.

a. Last Year's Accomplishments

See also NPM #1, 2, and 3.

Oversaw hearing screening statewide, UNHSP Advisory Committee, approved diagnostic centers, and outreach to families and providers.

Collected annual statistics, analyzed data to understand disparities in care, presented data to stakeholders, and tailored outreach efforts according to data analysis.

The UNHSP final CY 2010 data indicates that 72,698 (99.6%) of infants were screened for hearing loss (258 infants who died were not counted in the denominator).

Submitted abstracts and presented two sessions at the national EHDl Conference, "Scripting the Message" and "Audiological Diagnostic Center Guidelines" and submitted abstract to MCH Epi on Down Syndrome and Hearing Loss.

Disseminated Birth Facility Report Cards to the 50 facilities.

Finalized revised Guidelines for DPH approved Diagnostic Centers, collected protocols from 29 centers, and identified clinical support to review.

Took the lead in analyzing data in the new birth certificate system (Vital Information Partnership) and provided data reports to DPH senior leadership and Vital Records on missing data.

Held statewide trainings for DPH approved audiological centers: Cochlear Implant Panel (included all facilities that perform surgery); "What Families Can Expect from Genetic

Counseling;" "The Importance of Family Health History;" "Shared Reading;" and "Family Sign Language Programs."

Participated and identified numerous parents to attend Government and Accountability forums on deaf and hard of hearing education.

Presented at Joining Voices Conference on Cultural competency and state statistics.

Prepared protocol and gained legal access to utilize PELL data for analysis of research questions, including Down Syndrome and Enlarged Vestibular Aqueduct.

Continued working with MA AAP EHDI Champion Jane Stewart on issues related to primary care for children with hearing loss.

Compiled list of hearing aid loaner banks for families and providers.

Translated, proofed, printed, and distributed UNHSP brochures in eight additional languages for a total of 13 languages and continued to translate additional materials into Spanish.

Explored and utilized social media opportunities including enhanced website materials and regular e-mail blasts to families and providers.

Planned and hosted parents at "Ideas and Information: A Forum for Parents and Caregivers of Children with Hearing Loss" at Bentley College (hired a nationally known children's author Patricia Lakin to encourage early literacy for deaf and hard of hearing children).

Collaborated with national Hands and Voices and developed an educational video for providers and families called "Loss and Found."

Enhanced materials in Parent Information Kit, including: Moderate, Severe and Profound fact sheets, full-color map with DPH approved diagnostic centers, and additional materials in Spanish.

Continued QA/QI monitoring through data analysis and written reports to birth facilities and audiological diagnostic centers and achieved in CDC's data the lowest lost to follow-up rate in the nation in 2010

Chaired Data Collection, Research, Analysis and Information Systems workgroup for Prevent Blindness America and assisted in conducting interviews with PCPs. Provided TA regarding systems development of UNHSP for Prevent Blindness and participated in MCH Home Visiting community focus groups. Participated in national EHDI workgroups

Oversaw New England Border Babies data sharing agreement and continued to reach out to additional states to sign the agreement

Upgraded Childhood Hearing Data System to be more user friendly and enhance analysis of data

Participated, presented and supported various events and educational opportunities for parents

Collaborated with statewide Head Start to train programs to perform hearing screening

Continued to provide technical assistance and materials to other states

Family TIES and the DPH EHDI program collaborated to develop a workshop on cultural competency that was delivered to staff and at several conferences.

Parent contacts were identified in EI programs to support families with children with hearing loss

(>50 programs) and training and other educational opportunities were provided.

Outreach staff contacted or attempted to contact 1,635 families using phone calls and/or letters (approximately 3,000 phone calls were made); 2,713 audiologic diagnostic reports were entered into the system.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. The Universal Newborn Hearing Screening Program (UNHSP) conducts activities related to HP 2010 Goal # 28-11: all newborns are screened by age 1 month, diagnosed by 3 months if they do not pass screening, and enrolled in EI by 6 months. | | | X | |
| 2. The UNHSP reviews and approves all hospital newborn hearing screening protocols and disseminates new guidance, amended policies, and other information to birth facilities and diagnostic centers. | | | | X |
| 3. UNHSP staff conducts site visits to hospitals, mails monthly data quality reports, and provides technical assistance as needed. | | | | X |
| 4. UNHSP maintains an Advisory Committee and, with members, updates guidelines and protocols as needed per Joint Committee on Infant Hearing (JCIH) and other expert input, and provides training to 29 approved audiological centers 3 times a year. | | | | X |
| 5. Outreach staff assures that all children receive appropriate follow-up diagnosis and care and refers infants diagnosed with hearing loss to EI, primary care, and CSHCN programs. | | X | | |
| 6. UNHSP participates in local, regional and national workgroups and activities to develop information, resources and collaborations that continuously improve policies, services, and data. | | | | X |
| 7. UNHSP disseminates parent and provider information materials, including UNHSP brochures, parent information kits, provider information through the American Academy of Pediatrics Champion, meetings with graduate students, LEND Fellows and others. | | | X | X |
| 8. UNHSP offers parent-to-parent support to all families of children identified with hearing loss. Strengthened support includes regular contact via social media, an annual parent forum, and supporting family participation in educational opportunities. | | X | | |
| 9. The UNHSP partners with the EI Partnering for the Success of Children with Hearing Loss initiative to ensure appropriate services are available for infants and young children with hearing loss. | | X | | |
| 10. UNHSP evaluates its program, including surveying families and primary care providers, analyzing data re screening and loss to follow-up and publishing findings. | | | | X |

b. Current Activities

See Table above and NPM #1, 2, and 3.

Integrated newborn hearing screening data with PELL and presented Down Syndrome Project at

MCH Epi and national EHDI Conference.

Submitted abstracts and presented workshops at EHDI Conference on Cultural Competency/Life Course and Family Centered EHDI.

Continued strategic planning activities, including holding a statewide annual Parent Forum at Tower Hill Botanic Garden with a motivational teen panel and presentation on "Creating a Vision."

Supported attendance at regional and national educational/support conferences for EI Hearing Loss Contacts and Families.

Held Advisory Committee Meetings and DPH Approved Audiological Diagnostic Center Meetings and provided training on "What Families Can Expect from Genetic Counseling, The Importance of Family Health History" and UNHSP data analysis.

Held first statewide provider webinar for audiologists and EI providers on "Children with Unilateral and Mild Hearing Loss" presented by Anne Marie Tharpe, Ph.D. from Vanderbilt.

Continued social media campaign by developing a Facebook page and twitter accounts and began process for digital stories for website.

Participated on national AAP EHDI Lost to Follow-up workgroup, NICHQ Measures Advisory Committee and CDC's Executive, Family, Provider Education, Cultural Competency, EHDI PALS workgroups.

Worked in collaboration with the Advisory Committee and family partners to update birth facility newborn hearing screening guidelines and scripts.

c. Plan for the Coming Year

See also NPM #1, 2, and 3. Continue ongoing activities.

Collect hearing screening results, medical and demographic information through the VIP birth certificate system, distribute hearing screening information in 13 languages, contact by telephone and letters the >1,200 families whose infants do not pass the screen to ensure they receive follow-up, and make approximately 3,000 follow-up calls annually to providers and families.

Provide parent-to-parent support at diagnosis of hearing loss, including a written Parent Information Kit available in English and Spanish and develop new materials that encourage early literacy.

Work with Family TIES to train parents to provide family-to-family support and reimburse parents/support activities through stipends; utilize and maintain an email distribution list and contact information for parent support network; and host parent support forums to strengthen the parent community and develop a stronger voice for parents as stakeholders within EHDI.

Evaluate demographic and hearing loss risk factors that lead to EI loss to follow-up, pediatrician involvement in EI enrollment process, the quality and completeness of demographic and medical risk factor data, and the quality of annual EHDI in comparison with previous years' data and national data.

Analyze data to tailor outreach strategies, including those geared towards cultural competency.

Hold annual Parent Forum and initiate a new statewide family activity.

Send an educational mailing to all OB/GYN's in the Commonwealth.

Implement social media activities, including regular updates on Facebook page and creating blog entries on the Department's feed for topics like Deaf Awareness Month.

Add new states to Border Babies data sharing agreement.

Facilitate the creation of a father's network.

Continue to work with EI Task Force to strengthen knowledge about Specialty Services and resources for children who are Deaf or hard of hearing.

Support regional parent groups like Hear Together and Hear My Dreams, and facilitate communication between groups.

Partner with Specialty Service providers to educate parents on the variety of programs and communication opportunities available to them.

Develop Digital Stories to help families and providers understand various factors involved in early childhood development of children who are Deaf or hard of hearing and put them on the website.

Characterize risk factors, NHS results and hearing loss data for children with Enlarged Vestibular Aqueduct.

Develop manuscript and publish data on Down Syndrome and Hearing Loss.

Submit abstracts and present at National EHDI Conference.

Collaborate with CYSHN, Newborn Blood Screening, Home Visiting, Critical Congenital Heart Disease, Birth Defects, Head Start, insurers and other partners to enhance access to services and resources.

Create a survey to assess statewide birth hospital use, needs, awareness and movement towards EHR-S.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-------------|--|--|--|--|
| Annual Performance Objective | 2 | 2 | 1.2 | 1.5 | 0.5 |
| Annual Indicator | 2.3 | 1.2 | 1.9 | 0.2 | 0.2 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | MA Div. of Hlth Care Finance & Policy survey | MA Div. of Hlth Care Finance & Policy survey | MA Div. of Hlth Care Finance & Policy survey | MA Div. of Hlth Care Finance & Policy survey |
| Check this box if you cannot report the numerator because | | | | | |

| | | | | | |
|--|-------------|-------------|-------------|-------------|-------------|
| 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 |

Notes - 2011

Data source: Massachusetts Division of Health Care Finance and Policy (HCFP). The report on the 2011 survey has not yet been released (as of September 2012). We have estimated the same rate as for 2010.

Notes - 2010

Data source: Massachusetts Division of Health Care Finance and Policy (HCFP). "Health Insurance Coverage in Massachusetts: Results from the 2008-2010 Massachusetts Health Insurance Surveys;" Powerpoint summary presentation, December 2010. (www.mass.gov/dhcfp) The 2010 estimated uninsured rate for children (under age 19) of 0.2% fell from 1.9% in the 2009 survey.

The impact of the Massachusetts Health Care Reform Law is clearly demonstrated in the virtual elimination of uninsured children in the Commonwealth. Our out year Performance Objectives have been adjusted again accordingly.

Notes - 2009

Data source: Massachusetts Division of Health Care Finance and Policy (HCFP). "Health Insurance Coverage in Massachusetts: Estimates from the 2009 Massachusetts Health Insurance Survey;" Powerpoint summary presentation, October 2009. (www.mass.gov/dhcfp) The 2009 estimated uninsured rate for children (under age 19) of 1.9% (95% CI plus or minus 1.2 percentage points) is not significantly different from the 2008 estimate of 1.2% (same CI).

a. Last Year's Accomplishments

Title V programs continued to monitor implementation and participate in activities to encourage full coverage under Massachusetts Health Care Reform legislation. Since 2007, the coverage rate has remained at over 98%, including the expansion of Medicaid eligibility for children up to 300% of the FPL. It reached an all-time high of 99.8% according to 2010 annual survey by the Division of Health Care Finance and Policy. The 2011 survey results will not be released until August, 2012 but are expected to be comparable. Massachusetts has the highest rate in the country. Public outreach and information continued to inform families both on the benefits they are eligible for and on their responsibilities under the law (e.g. purchasing insurance under various subsidies).

Of children in EI, 99% have private or public insurance. The remaining 1% receive state-funded EI services, and assistance is provided by EI staff to assess, as appropriate, public health insurance benefits.

Early Intervention benefits under Medicaid expanded effective July 1, 2009 with the addition of Medicaid coverage for developmental specialists. All professional disciplines are now covered by MassHealth. This helps assure equitable EI services for all participants.

EIPP continues to foster strong relationships with two out of the four Massachusetts MassHealth MCOs to provide reimbursement for home visits and groups, expanding insured benefits for EIPP participants and stretching program funds for uncovered services. MCO's are utilizing identified CPT codes and reimbursement rates for home visiting services to pregnant and post partum women and their infants. MDPH continues to cover the costs of providing services to families not on the two partner MCOs.

DPH Care Coordinators assisted 291 families through the Family Support Fund to reimburse costs of goods and services related to raising a child with special health care needs. These expenses tend not to be medical in nature and therefore not covered by health insurance.

The ESHS programs referred a total of 5,612 students for health insurance.

MassHealth continues to reimburse pediatric health providers for fluoride varnish application during well-child visits. OOH has developed a tool kit and conducts trainings of medical providers, focusing on community health centers. Legislation has created a public health dental hygienist category to work without the supervision of a dentist. Dental hygienists can now bill MassHealth directly, increasing the number of low income children receiving sealants and fluoride.

MDPH SBHC Quality Standards require SBHCs to assist uninsured students in determining eligibility for and enrollment into a state health insurance plan. Some electronically enroll students in MassHealth on-site using the Virtual Gateway at the SBHC (all are offered training) and others refer patients to another community location where they can be enrolled. SBHC's serve all children and youth regardless of their ability to pay and until their health insurance plans go into effect. SBHC data suggest that up to 9% of enrolled students do not have insurance at some point each year.

In collaboration with the UMass Medical School, the Massachusetts Office of Medicaid is leading the Within Our Grasp: Achieving Full Insurance for Massachusetts Kids project as a grantee of the Maximizing Enrollment for Kids program funded by the Robert Johnson Foundation. Massachusetts is one of only 8 states to receive these 4-year grants to create an even more seamless and continuous enrollment and eligibility process (e.g "family applications") to decrease the proportion of children who are MassHealth eligible but un-enrolled. An independent diagnostic assessment of MA found churning among children to be an area for potential improvement, with paperwork requirements for continuous coverage a major issue. The state is responding with an action plan that aims to increase retention, improve data use and capacity, and improve customer service. Requesting federal approval for 1-year continuous coverage for children regardless of family income or address changes is being considered.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. All BFHN and other DPH programs (e.g., ESHS, SBHCs) with direct family contact screen for health care access and insurance coverage, make referrals, and provide assistance to access coverage and care appropriate to the program and family. | | X | | |
| 2. DPH works with Medicaid/SCHIP and the Health Connector on joint efforts to promote and sustain enrollment. DPH staff will continue to participate in EOHHS Health Reform development and implementation and monitor access for MCH populations. | | X | | X |
| 3. DPH works with provider, professional, and community groups to maintain awareness of Health Care Reform and the multiple options and programs available, and to facilitate enrollment. | | | | X |
| 4. DPH works with community and advocacy groups to maintain | | X | | X |

| | | | | |
|--|--|---|--|---|
| awareness of programs and to facilitate enrollment. | | | | |
| 5. Training and technical assistance is offered to providers and parents on SSI and public benefits that provide health insurance for CSHCN. | | X | | X |
| 6. FOR Families, EIPP, FRESH Start and MHVI, and other home visitors provide information to families on public benefits and assist with enrollment in health insurance. | | X | | |
| 7. The SHU updates information on insurance through emails to school nurses and presents programs on the topic through the School Health Institute at Northeastern University. | | | | X |
| 8. See also activities for NPM #4, re adequate insurance for CSHCN. | | X | | X |
| 9. BFHN and MDPH monitor developments under national health care reform (PPACA) and initiative planning, policy development, and applications for funding to maximize benefits for Mass. children, in collaboration with EOHHS and other partners. | | | | X |
| 10. | | | | |

b. Current Activities

See also Summary Chart and NPMs #2 and 4.

DPH assures that all existing and new programs continue to focus on enrolling all uninsured children and families in appropriate insurance plans and address incremental changes and developments as plan options change.

BFHN continues to work with MassHealth and the Health Connector to assure children and families are enrolled in appropriate health coverage plans, to monitor effects of recertification and possible disenrollment due to premium nonpayment. DPH participates in quality and cost control council and activities.

The Within Our Grasp project continues.

c. Plan for the Coming Year

See also NPM #4. Continue ongoing activities.

BFHN will continue to work with MassHealth, the Health Connector, and others to assure children and families are enrolled in appropriate health coverage plans and to monitor effects of any changes in health care reform policies, procedures, or options under the current severe budgetary strains and various proposals to control costs. Effects on current programs, such as EI, Family Planning, and EIPP, will continue to be reviewed and programs modified as indicated.

EIPP, MHVI, FRESH Start and FOR Families, and other home visiting programs, when working with their clients and homeless families, will continue to assess health insurance status and work with families to enroll them and their children as needed. MHVI will collect data on well-child visits for all families receiving home visiting in 17 high need communities and will monitor whether all families members have continuous health care coverage.

Efforts continue to enhance capacity for electronic, on-site SBHC access to MassHealth and Connector programs enrollment and to provide or assure training in how to utilize this computerized system.

With virtually all children in the Commonwealth having either public or private insurance, our

focus is on improving continuous and timely coverage, assuring appropriate use of health care services, and promoting high quality care for all. We will also continue to closely monitor the potential impact of national health care reform under the Patient Protection and Affordable Care Act, both for possible conflicts with current Massachusetts regulations and procedures and for additional opportunities to further improve both health insurance availability and covered services.

The Within Our Grasp project continues. The state Senate version of the state FY13 budget calls for MassHealth to pursue all reasonable efforts to automatically renew eligible children and families into the MassHealth program through the CHIPRA express-lane eligibility option. The bill also would establish a study committee to investigate the feasibility and cost of continuous MassHealth eligibility for children under the age of 19. The committee is to formulate relevant Medicaid state plan amendments, cost projections and IT specifications necessary to implement continuous eligibility for children by 6/30/2014.

EOHHS would also be required to conduct an investigation of all federal and state assistance programs to determine which share eligibility requirements with MassHealth and which could feasibly share data with MassHealth for the purposes of renewing eligible children and their eligible parents in MassHealth.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-------------|------------------------|------------------------|------------------------|------------------------|
| Annual Performance Objective | 34 | 34 | 33.5 | 33 | 32 |
| Annual Indicator | 33.8 | 33.5 | 33.7 | 32.4 | 33 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | Mass. WIC Program data | Mass. WIC Program data | Mass. WIC Program data | Mass. WIC Program data |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 33 | 32 | 31 | 30 | 28 |

Notes - 2011

Data Source: Calendar year 2011 Massachusetts WIC Program PedNSS data. This is the final year for PedNSS data. The rate has not improved. For WIC children, 16.6% were overweight (\geq 85th percentile and $<$ 95th percentile) and another 16.4% were obese (\geq 95th percentile).

Notes - 2010

Data Source: Calendar year 2010 Massachusetts WIC Program PedNSS data. The rate has improved slightly.

Notes - 2009

Data Source: Final calendar year 2009 Massachusetts WIC Program PedNSS data, from the CDC report. The rate has remained essentially unchanged.

a. Last Year's Accomplishments

WIC is a unique health and nutrition program serving women and children with -- or at risk of developing -- nutrition-related health problems. Designed to influence lifetime nutrition and health behaviors, WIC provides nutrition education and counseling, free nutritious food and access to health care to low- to moderate-income pregnant women, infants and children under five. WIC plays an important role in assisting families in achieving positive nutritional habits and healthy weights.

Program participation reflects an emphasis on services to high-risk and minority populations: 31% of participants are Hispanic, 19% Black, 5% Asian/ Pacific, <1% were Native American, and 45% White. Fifty-four percent of participants were classified as high risk due to factors such as low hemoglobin/hematocrit or other nutrition related medical conditions. A total of 229,911 individuals and their families received WIC benefits at least once during FY11. Twenty-nine percent of participants were pregnant, breastfeeding or non breastfeeding postpartum women, 18% were infants, and 53% were children under five.

According to calendar year 2010 Massachusetts PedNSS data from the CDC report, 32.4% of 2-5 year olds had a BMI >85% for their age, improved from 33.7% in 2009. This suggests that Massachusetts rates for overweight in young children are improving; data from September 2011 suggest that this trend is continuing, but we await 2011 data PedNSS data to confirm.

The Massachusetts WIC Nutrition Program continue to implement the new WIC food package containing whole grains, low-fat dairy, and fruits and vegetables. Policy changes were made to allow participants to spend more than their allotted fruit and vegetable check and to "pay the difference". The pilot program allowing the use of the WIC cash value fruit and vegetable voucher at select Farmers' Markets was expanded. Distribution procedures for the Farmers' Market Nutrition Program coupons were altered and resulted in an improved redemption rate.

Massachusetts WIC expanded the availability of a series of cooking classes for WIC parents of preschoolers by utilizing the Operation Frontline curriculum to WIC & Head Start families. A demonstration project utilizing WIC staff as supermarket tour guides was developed and implemented in the local WIC program serving Franklin, Hampshire and North Quabbin Counties.

The Massachusetts WIC Nutrition Program continued to provide nutrition services consistent with the "Touching Hearts and Minds: Using Emotion-Based Messages to Promote Healthy Behaviors" initiative in both individual appointments and in facilitated group discussions with WIC parents. Nutrition services are consistently directed at promoting behaviors tied to maintaining a healthy weight. New educational materials related to healthy eating behaviors for WIC participants were designed and distributed to local programs using this model.

The WIC Program began statewide rollout of findings and final deliverables of the USDA Special Projects Grant, "Getting to the Heart of the Matter (GHM): Using Emotion-Based Techniques to Implement the Value Enhanced Nutrition Assessment" that uses emotion-based techniques in the WIC nutrition assessment to foster meaningful and productive nutrition education sessions. Project materials and training resources can be found at www.gettingtotheheartofthematter.com.

Massachusetts WIC completed the third year of the Breastfeeding Performance Improvement Project, which was designed to increase breastfeeding duration as an intervention to promote healthy weights in children. The Breastfeeding Social Marketing Campaign, designed to reinforce the role of the WIC Program in breastfeeding support for both parents and health care providers, was implemented. Many local agencies selected a staff member to become a certified training for the Happiest Baby on the Block program, allowing them to provide classes to WIC families that

teach parents methods to calm their fussy babies without overfeeding.

Lastly, work began on the adaptation of the FitWIC initiative as Massachusetts WIC explored mechanisms for promoting physical activity among its preschool aged participants.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. WIC local programs screen and assess BMI and provide caregivers with information regarding child's weight. | X | | | X |
| 2. Provide caregiver messages included in "Steps to Healthy Weight in Children" which promote good nutrition and feeding patterns and encourage physical activity. | | X | | X |
| 3. Partner with medical providers to coordinate nutritional care and provide consistent nutrition and physical activity messages to promote healthy weights, utilizing both the Weigh of Life and Touching Hearts messages and materials. | X | | | X |
| 4. Ensure new staff training includes approaches to talking effectively with parents about their child's weight and ways to ensure a healthy weight for their child, highlighting emotion-based, participant-centered model. | | X | | X |
| 5. WIC staff utilizes emotion-based service methodology to provide WIC families with messages about healthy eating, increased physical activity, and healthy weights, utilizing Touching Hearts, Touching Minds materials. | | X | | X |
| 6. Annually communicate trends in state and local WIC program rates for children with BMI's at or above 85th percentile, review current efforts and strategize individual program activities and initiatives to improve rates. | | | | X |
| 7. Implement USDA's Value Enhanced Nutrition Assessment initiative to ensure the completion of a participant-centered nutrition assessment process. | | | | X |
| 8. Through the Getting to the Heart of the Matter grant activities achieve a nutrition assessment interaction that is emotion-based and participant-centered. | | | | X |
| 9. Develop weekly messages for the Mix FM Nutrition Buzz and other media outlets promoting healthy eating and physical activity. | | | X | X |
| 10. Train home visiting staff in EIPP, FRESH Start and MHVI on child nutrition to promote healthy weight | X | X | | X |

b. Current Activities

WIC implemented and expanded the "Getting to the Heart of the Matter" project statewide, using client-centered, emotion-based based tools and techniques to perform more meaningful, productive nutrition assessment and set the stage for behavior change.

The NETF and TOTE workgroups provide activities to promote healthy weights, review education materials, provide healthy recipes and focus on staff wellness for the WIC Program and other public health staff across the state. State office and Roxbury WIC staff are collaborating with Children's Hospital on a NICHQ funded project to align obesity prevention messages among providers.

Launch the FitWIC training and implementation model, adapting Head Start's I am Moving I am Learning curriculum to promote physical activity within WIC facilitated group education.

Promote healthy eating messages through the Nutrition Buzz and the Department's Mass In Motion initiative. Continue performance improvement and launch social marketing projects to promote breastfeeding. Continue to support the Happiest Baby on the Block project.

Expand the implementation of the new WIC food package by increasing the Farmers' Market pilot project with the fruit and vegetable voucher. Continue to expand cooking classes for WIC parents of preschoolers utilizing the Cooking Matters (formerly Operation Frontline) curriculum to WIC & Head Start families. Widen the availability of supermarket tours to participants in several additional local programs.

c. Plan for the Coming Year

Continue ongoing activities.

Continue to support the Implementation of the new WIC food package, which supports healthy weight in children by providing fruits, vegetables, whole grains and low-fat milk. Incorporate any changes instituted by USDA upon release of the Final Rule.

Support and expand the implementation of the Fit WIC initiative.

Revise the Weigh of Life training curriculum, collaboration materials, and nutrition education materials to align with updated evidence-based practices in obesity prevention among preschoolers.

BFHN staff are collaborating with Harvard School of Public Health to adapt and pilot an evidence-based curriculum in home visiting programs that promote healthy weight. Mommy and Me is an evidence-based intervention to promote healthy eating and physical activity behaviors among mother-infant pairs in the first 6 months of life.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|--|-------------|----------------|----------------|----------------|----------------|
| Annual Performance Objective | 6 | 9 | 9 | 9.3 | 11.5 |
| Annual Indicator | 9.2 | 9.8 | 11.5 | 6.7 | 9.1 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | Mass. PRAMS | Mass. PRAMS | Mass. PRAMS | Mass. PRAMS |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average | | | | | |

| | | | | | |
|-----------------------------------|-------------|-------------|-------------|-------------|-------------|
| cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 9.1 | 9 | 9 | 9 | 9 |

Notes - 2011

Data Source: Massachusetts PRAMS. 2011 PRAMS data are not yet available. We estimated a rate based on the average of 2009 and 2010 data.

Notes - 2010

Data Source: Massachusetts PRAMS. 2010 data. Third trimester smoking appeared to have gone down in 2010. Since the wording of the questions in 2010 was similar to that of 2009, we believe that the 2010 drop may due to a yearly variation. Additional years of data are needed to understand the direction of the trend.

Notes - 2009

Data Source: Massachusetts PRAMS. 2009 data. Third trimester smoking appears to have gone up in 2009. We believe that this may be due to the wording of the question in 2009 which was slightly different from that of 2007-2008. In 2007-2008, mothers were asked first "Have you smoked at least 100 cigarettes in the past 2 years?" and those who answered "yes" were then asked the question, "In the last 3 months of your pregnancy, how many cigarettes did you smoke on an average day? (A pack has 20 cigarettes.)"

In 2009, mothers were asked first: "Have you smoked any cigarettes in the past 2 years?" and those who answered "yes" were then asked the question, "In the last 3 months of your pregnancy, how many cigarettes did you smoke on an average day? (A pack has 20 cigarettes.)."

Trend data from 2009 forward should be more comparable.

a. Last Year's Accomplishments

See also Priority Need # 6 for additional activities.

This report for NPM #15, smoking in the third trimester highlights activities that are focused on smoking cessation after a pregnancy begins.

Data about smoking during the third trimester are not available on the Massachusetts birth certificate. PRAMS, which asks a representative sample of Massachusetts women who gave birth about smoking in the third trimester, reported final findings in 2010 (for calendar 2007) about smoking in the third trimester.

We have noted that 3rd trimester smoking appears to have gone up in 2009. We believe that this may be due to the wording of the question in 2009 which was slightly different from that of 2007-2008. In 2007-2008, mothers were asked first "Have you smoked at least 100 cigarettes in the past 2 years?" and those who answered "yes" were then asked the question, "In the last 3 months of your pregnancy, how many cigarettes did you smoke on an average day? (A pack has 20 cigarettes.)" In 2009, mothers were asked first: "Have you smoked any cigarettes in the past 2 years?" and those who answered "yes" were then asked the question, "In the last 3 months of your pregnancy, how many cigarettes did you smoke on an average day? (A pack has 20 cigarettes.)." Trend data from 2009 forward should be more comparable.

2010 PNSS data (the latest available) indicated that 10.0% of low income women participating in the Massachusetts WIC program smoked during their last 3 months of pregnancy, a slight decrease from 10.6% in 2009, 11.3 in 2008 and from 12.4 in 2006.

Due to reductions in funding, the Massachusetts Tobacco Control Program (MTCP) Smoker's Helpline to promote services and materials tailored for pregnant women who smoke has been discontinued, along with its programs at rural birth hospitals in Western Massachusetts to train hospital and community-based healthcare providers to conduct and track brief interventions with

pregnant smokers. Both programs had been showing good success at reducing smoking rates.

Pregnant women and women with young children continued to have access to smoking cessation benefits through the new MassHealth smoking cessation benefit. MTCP had provided extensive technical assistance to help MassHealth design a smoking cessation benefit that provided counseling and pharmacotherapy for pregnant women and women with young children. This benefit has been widely used.

In June 2011, MDPH epidemiologists presented "Place matters: differential town rates of smoking during pregnancy among Medicaid recipients in Massachusetts" to the Western Regional MCH Epidemiology Conference in San Francisco.

EIPP and FRESH Start, home-visiting programs targeting high-risk pregnant women, screened, provided brief intervention and offered referrals for pregnant women. FRESH Start works exclusively with substance using women and sees high rates of smoking among their clients. Staff have been trained in motivation interviewing to impact behavior change. Second hand smoke education has been added to the list of topics to be covered with FRESH Start pregnant clients.

In FY11, 20% of EIPP Participants reported tobacco use at intake and 20% of EIPP Participants reported smoking during the last three months of pregnancy.

In FY11, a presentation entitled "Place matters: differential town rates of smoking during pregnancy among Medicaid recipients in Massachusetts" concluded: 1) maternal demographic characteristics of Medicaid recipients for prenatal care were strong predictors of smoking during pregnancy; 2) adjusting for maternal demographic characteristics in the Medicaid population diminished the variation of smoking rates across Massachusetts communities; and 3) adjusting for additional pregnancy characteristics and preexisting maternal medical conditions did not diminish the town variation in smoking among publicly insured pregnant women. The results suggest an independent association of town level characteristics with odds of smoking among pregnant women enrolled in Medicaid beyond individual level characteristics. This suggests that strategies to reduce smoking among pregnant women may need to address community characteristics, practices and policies.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. FOR Families, EIPP and MHVI home visitors screen and assess for tobacco use at regular intervals during pregnancy and postpartum, and make referrals as needed. Formal collaboration with MTCP and QuitWorks provides smoking cessation services. | | X | | X |
| 2. WIC services assess for smoking during pregnancy and provide information and counseling on smoking cessation, offering and assisting interested women with enrollment into QuitWorks, a smoking cessation program. | | X | | X |
| 3. PRAMS collects information from new mothers between 2 and 6 months postpartum, specifically assessing the proportion of women giving birth in Massachusetts who smoke in the last three months of pregnancy. | | | | X |
| 4. The MCH program works closely with the Massachusetts Tobacco Control Program (MTCP) on program development, new initiatives, training and technical assistance. | | | | X |
| 5. EIPP home visitors collect this data element for all EIPP | | | | X |

| | | | | |
|--|--|---|---|---|
| enrolled pregnant and postpartum women. | | | | |
| 6. MHVI home visitors screen pregnant women for tobacco use with the SBIRT (Screening, Brief Intervention and Referral to Treatment) and provide information to women on the risk of smoking in pregnancy as needed. | | X | | |
| 7. FRESH Start continues to screen, provide brief intervention and referrals for pregnant women who smoke using motivational interviewing techniques. | | X | | |
| 8. EIPP staff provide extensive counseling support for clients who use tobacco. | | X | | |
| 9. The Massachusetts Smoker's Helpline and Quitworks, funded by the MTCP, provide services and support to individuals and clinicians. | | X | X | X |
| 10. | | | | |

b. Current Activities

PRAMS analyses for 2009 were finalized in collaboration with the CDC PRAMS team. We reported the prevalence of cigarette smoking in the last 3 months of pregnancy for 2008 and 2009 calendar year (the most recent data available) and improved the precision of our estimates. The CSTE fellow's study on "Evaluation of Maternal Smoking Surveillance Systems in Massachusetts," which compared smoking reported on birth certificate and PRAMS using the 2007-2008 PRAMS data was completed. PRAMS data captured more maternal smoking prior to and during pregnancy than the birth certificate. While the two data sources were in good agreement for both of these indicators, combining the data revealed a greater percentage of maternal smoking than either source alone. Recommendations include working with tobacco cessation program to identify women who are not reporting smoking on the birth certificate, and encouraging universal screening for maternal smoking with referrals to cessation programs. PRAMS also offers data on smoking after delivery. Surveillance systems that capture maternal smoking behaviors are critical for MCH policy and program development.

MTCP conducted an analysis in FY09 to assess the degree of underestimating of smoking on the birth certificate. The analysis and a report were completed for release during FY10. MTCP later decided to add a cotinine validation to the analysis and the report has been resubmitted for review. It was published in the Public Library Journal during FY12.

c. Plan for the Coming Year

Continue ongoing activities.

Due to continued budget restrictions, the Massachusetts Tobacco Control Program will be unable to restart any of the programs discontinued since FY09. The Massachusetts Smoker's Helpline and Quitworks will still be operational in FY13.

Reporting the prevalence of cigarette smoking in the last 3 months of pregnancy over time from the PRAMS database will continue as additional years of data become available (2007-2010 for FY13). This will improve the precision of our estimates and enhance our understanding of related maternal characteristics, risk factors, and sub-populations to target for interventions when funds permit.

All staff from MHVI and EIPP home-visiting programs for pregnant women will receive training and information on SBIRT (screening, brief intervention and referral to treatment) for clients who smoke using motivation interviewing techniques. Data will be collected and reported on the number of families screened and referred for treatment for tobacco and other use of unhealthy substances.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-------------|---------------------|---------------------|---------------------|---------------------|
| Annual Performance Objective | 4.3 | 4.3 | 4.2 | 4.1 | 4 |
| Annual Indicator | 3.6 | 3.5 | 4.1 | 5.0 | 5 |
| Numerator | 16 | 16 | 19 | 23 | |
| Denominator | 442849 | 453532 | 459014 | 462137 | |
| Data Source | | Mass. Vital Records | Mass. Vital Records | Mass. Vital Records | Mass. Vital Records |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 5 | 4.5 | 4.5 | 4.5 | 4.5 |

Notes - 2011

2011 death data are not available. See 2010 for the most recent preliminary data and see the Note for 2010 for data sources and other comments. We have estimated a rate in line with 2010 data.

Notes - 2010

2010 death data are taken from MDPH Vital Records for calendar years 2008 - 2010. The 2010 data are still preliminary and subject to change in the final file. Rates are calculated as rolling 3-year averages. (I.e. the 2010 numerator is the sum of the 2008, 2009, and 2010 numbers of deaths (19, 19, and 30 respectively) and the denominator is the sum of the most recent Massachusetts population estimates for the age group for the same years, as provided by the MDPH Bureau of Health Information, Statistics, Research and Evaluation. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere.

The large increase in suicide deaths in 2010 (from 19 each of the previous years to 30) is due to suicides among white males ages 18 and 19. There are no geographic clusters. Overall, the suicide trend is also higher across all age groups as well. As these data just became available, we are just beginning further analyses to better understand the data. Although our Child Fatality Review system only goes through age 17, the data are being reviewed and discussed in those forums as well to identify possible interventions and better approaches to suicide prevention efforts.

Because of the increase, and its continuing effect on the next two years, we have modified our projections and are predicting only slight improvement from the current rate to 4.5 through 2016.

Notes - 2009

2009 death data are taken from MDPH Vital Records for calendar years 2007 - 2009. The 2009 data are still preliminary and subject to change in the final file. Rates are calculated as rolling 3-year averages. (I.e. the 2009 numerator is the sum of the 2007, 2008, and 2009 numbers of deaths (19, 19, and 19 respectively) and the denominator is the sum of the most recent Massachusetts population estimates for the age group for the same years, as provided by the MDPH Bureau of Health Information, Statistics, Research and Evaluation. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere.

a. Last Year's Accomplishments

MDPH received its 9th year of state funding for a Suicide Prevention Program. With leadership and funding from the Program, activities for adolescents, their parents, teachers and caregivers included the following:

- The 10th Annual Suicide Prevention Conference was held with participation by 800 providers and advocates.
- A new program was introduced in pilot form to 6 MA schools --"Break Free From Depression" a training tool for teachers.
- Two free QPR Instructor Certification Trainings were held for 80 substance abuse providers and youth workers. The certified QPR trainers conducted 25 trainings in which 457 individuals participated.
- DPH staff participated in all Massachusetts Coalition for Suicide Prevention activities and provided technical assistance to four developing Regional Coalitions.
- Six AMSR trainings were held for 324 mental health and substance abuse clinicians.
- American Foundation for Suicide Prevention training was given to 35 facilitators on how to lead survivor support groups.
- The Program assisted several communities to develop prevention strategies in response to youth suicides.
- The Program sponsored a one day camp experience for survivor families who have lost a loved one to suicide. 22 families participated
- The Program also continues to disseminate suicide prevention materials.

Preliminary FY11 results of the continuing School Health CQI 911 study indicate that 26% of student health encounters are for behavioral health. The majority in elementary school are for out-of-control behavior. The majority in middle and high school are for suicide ideation/suicide attempts and a sprinkling of homicidal ideation. An increase in the calls to the Mobile Crisis Units is a good indication that children are getting more appropriate care than sending them to the ERs.

In FY11, the School Health Institute oriented approximately 200 new school nurses; the orientation included a segment on mental health and the school nurse's role. The summer institute, attended by 200 school nurses, had presentations on "What you need to know about bullying."

The ESHS school districts reported approximately 77,800 student encounters in which mental health counseling was the primary reason for the visit; 27% of the ESHS districts had emotional support groups for

students, with an average of 98 meetings and 294 student participants monthly. In addition, 15% of the ESHS districts provided anger/conflict/violence management support groups, with an average of 20 group meetings and 62 student participants monthly. Nurses reported diagnoses of depression at a rate of 11.6 per 1,000 students in the ESHS districts.

3.64% of the 7,656 students ages 15 through 19 who had at least one visit to the SBHC were identified to be at risk for suicide attempt [as defined by suicidal ideation (2.93%), previous attempt (1.82%), and/or suicide plan (1.19%).

SBHC clinicians are required to screen students for suicidal ideation and plan upon observing clinical signs of depression and/or if screening instruments (i.e. Y-PSC, PHQ9) indicate a risk of depression/suicide. Students are assessed for the presence of a suicide plan including availability of lethal methods to execute the plan and past history of suicidal plan/attempt. SBHC clinicians have extensive knowledge of referral network including CBHI for psychiatric stabilization services and urgent psychopharmacology intervention. All students seen in SBHCs who are identified with a 'suicide plan' are referred for immediate crisis intervention to stabilize them safely. SBHC clinicians collaborate with other treatment providers to ensure that risk management/safety plans are well developed and monitored with vigilance. In FY11, 17.08% of the 7656 students aged 15 through 19 years who had at least one visit to the SBHC were identified to be at risk for depression. Of these students, 99.39% were assigned a follow up plan by the SBHC clinician.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. The Suicide Prevention Program carries out a comprehensive array of suicide surveillance, intervention and prevention activities, seeks to identify adolescents at risk for suicidal behavior and intervene with an appropriate preventive strategy. | X | X | | |
| 2. Safe Spaces for Gay, Lesbian, Bisexual and Transgender Youth Program addresses suicide risk among GLBT youth; working with community based providers to promote healthy youth development and to create safe spaces within schools and communities. | | | X | X |
| 3. Extensive training and technical assistance is provided to SBHC clinicians and school nurses (ESHS) in mental health and suicide screening and prevention, and they screen and refer for treatment. | | | | X |
| 4. Provide post-intervention services with suicide survivors and affected schools through a statewide contract. | X | | | |

| | | | | |
|---|--|---|--|---|
| 5. Sponsor trainings, an annual conference, and seminars on suicide prevention; promote and use curricula for various providers. Update data and prevention resources. | | | | X |
| 6. School nurses do assessment and referral for depression and other mental health issues for children in grades K-12. This is a requirement of the ESHS grants and the School Health Manual provides information on this subject. | | X | | X |
| 7. SBHC standards require annual risk and resiliency assessments with validated screening instruments. All clinicians are trained in the child symptom checklist. Several use SOS and others use additional validated instruments (including MHP-Q9). | | X | | X |
| 8. Implement a federal SAMHSA grant focused on at-risk youth in three areas of the state with the highest rates of youth suicide and self-injury, pending continued funding. | | | | X |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

See also Summary Chart.

Selected Suicide Prevention Program activities for adolescents, their parents, teachers and caregivers included the following:

- Supported a youth mental health referral service in 8 cities and towns with a higher than state average incidence of youth suicides or self-injury
- ? Supported training of 100 youth in the Youth Health Connection Peer Leadership Program
- Participated in all Massachusetts Coalition for Suicide Prevention activities and provided technical assistance to four Regional Coalitions and two developing regional coalitions.
- Assisted several communities to develop prevention strategies in response to youth suicides.

The SHU and Northeastern University School Health Institute continued to collaborate on a three-credit graduate online course in school mental health.

The SHU is working closely with the Attorney General's Office, the Boston Police Department, MGH, and a host of other agencies to address the issues of commercial sexual exploitation of children (CSEC). It has conducted a series of workshops and, with Northeastern U. and the Injury Prevention program, created a series of six modules on CSEC. An article has been accepted for publication on this issue.

c. Plan for the Coming Year

Continue ongoing activities to build sustainability of substantial new activities implemented in this area during FY11 and FY12.

Continue the graduate course in mental/behavioral health.

Continue to analyze the behavioral health 911 data and to develop initiatives to determine how

best to reduce these calls, e.g., teaching de-escalation techniques, assigning a mature staff member to touch base with fragile students once a day.

The SBHC program will continue to support enhanced mental health/substance abuse services in the funded SBHCs, with the goal of disseminating identified best practices throughout the state network of SBHCs. The program will continue to host training for primary care clinicians on youth mental health disorders, including recent developments in the prevention and treatment of depression and psychosis in adolescent and young adults.

The Suicide Prevention Program has received a 3-year SAMHSA Garrett Lee Smith youth suicide prevention grant starting August 1, 2012. The grant will provide support for suicide prevention activities in areas of the state with a higher than average rates of youth suicide and/or self-injury. The grant will support skills training for staff in organizations that work with: homeless and runaway youth; youth in residential drug and alcohol treatment; GLBT youth; and school-based health center staff, school personnel and parents.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-------------|---------------------|---------------------|---------------------|---------------------|
| Annual Performance Objective | 86 | 86 | 88.5 | 86.5 | 87.5 |
| Annual Indicator | 88.5 | 85.7 | 87.7 | 87.6 | 87.6 |
| Numerator | 886 | 798 | 822 | 793 | |
| Denominator | 1001 | 931 | 937 | 905 | |
| Data Source | | Mass. Vital Records | Mass. Vital Records | Mass. Vital Records | Mass. Vital Records |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 87.6 | 87.7 | 87.8 | 88 | 88 |

Notes - 2011

2011 birth data are not available. We have estimated the same rate as that for 2010. See 2010 for the most recent actual data and see the Note for 2010 for data sources and other comments.

Notes - 2010

Data on VLBW, birth hospitals, and resident births are from MDPH Vital Records for calendar year 2010, the most recent data available. The nine Level III units are at Baystate Medical Center, Beth Israel Deaconess, Boston Medical Center, Brigham and Women's, Massachusetts General Hospital, Medical Center of Central Massachusetts, New England Medical Center, South Shore Hospital, and St. Elizabeth's Medical Center. Data include only those resident births that occurred in-state at Massachusetts hospitals, as the birth file used for analysis does not contain the necessary information (specific hospital of birth) for births to residents at out-of-state facilities to be categorized by Level III facility. In one region of the state enough births occur out-of-state (in Rhode Island) to distort the statistic otherwise.

The rate remained unchanged in 2010 and we have not yet projected further improvement for future years. Massachusetts has already surpassed the HP 2020 target of 83.7%.

Notes - 2009

Data on VLBW, birth hospitals, and resident births are from MDPH Vital Records for calendar year 2009. The nine Level III units are at Baystate Medical Center, Beth Israel Deaconess, Boston Medical Center, Brigham and Women's, Massachusetts General Hospital, Medical Center of Central Massachusetts, New England Medical Center, South Shore Hospital, and St. Elizabeth's Medical Center. Data include only those resident births that occurred in-state at Massachusetts hospitals, as the birth file used for analysis does not contain the necessary information (specific hospital of birth) for births to residents at out-of-state facilities to be categorized by Level III facility. In one region of the state enough births occur out-of-state (in Rhode Island) to distort the statistic otherwise.

a. Last Year's Accomplishments

See also NPM 15.

After concerns about the smaller percentage of VLBW infants born at Level III facilities in Massachusetts, revised state Hospital Licensure Regulations (105 CMR 130.000) governing maternal and newborn services were promulgated by DPH and put into effect in March 2006. Since the regulations were promulgated, the BFHN and the Bureau for Health Care Safety and Quality (BHCSQ) continue to collaborate on a system of reviewing services in each birth hospital to determine an appropriate level designation.

In FY11, the MDPH Medical Director continued to serve as the joint-chair of the Perinatal Advisory Committee (PAC) whose members represent all hospital levels of care, all regions in Massachusetts, and each professional organization identified as a key stakeholder (e.g. MA ACOG, MCAAP, MNA, and the Massachusetts Medical Society). The PAC advises DPH on maternal and newborn policy and regulations, advises on regulation waiver requests and monitors the impact of the regulatory changes on care. In addition to reviewing where VLBW infants are born, the PAC addressed other strategies to improve the standard of care for neonates, including the need to standardize protocols for treatment of substance exposed newborns, to establish a statewide neonatal death review process, and to support policies that encourage exclusive breast milk feeding in birth hospitals.

The Perinatal Data Workgroup has gathered and analyzed aggregated, de-identified data to report back to the PAC. The purpose of these reports is to provide the information needed for the PAC to make clinical and systems recommendations to increase the percentage of VLBW infants born at appropriate facilities for their medical needs. The first report was submitted in FY11 and the PAC determined that it was useful for the Perinatal Data Workgroup to continue examining factors that impact low birthweight and how it is managed in birth hospitals.

The Expert Review Group (ERG), established in May 2010 continues to work with BFHN and

MDPH BHCSQ to review and evaluate specific data related to newborns born in Level II maternal and newborn hospitals who require respiratory support, i.e. Continuous Positive Airway Pressure (CPAP) or STMV and to evaluate the care and management of newborns 32-33 6/7 weeks born in two Level II hospitals that do not provide CPAP services. DPH has developed guidelines for neonatal CPAP services provided in six Level IIB hospitals and neonatal Short Term Mechanical Ventilation (STMV) waivers currently provided in one Level IIB hospital. The ERG was established to advise DPH on the appropriateness of care of newborns who are born at a Level II hospital rather than a Level III hospital and who are at risk of requiring respiratory support.

Title V and the Betsy Lehman Center for Patient Safety and Medical Error Reduction disseminated the results and recommendations from a report with extensive input from an expert panel on obstetrics, with a focus on developing standardized protocol to reduce medical errors during labor and delivery. Recommendations are grouped into several topic areas: Electronic Fetal Monitoring; Cesarean Births (including Trial of Labor after Cesarean (TOLAC)); Disparities in Perinatal Outcomes; Inductions; and Staffing and Communications. In addition, several members of the expert panel collaborated with members of the Maternal Mortality and Morbidity Committee to develop protocols for addressing hemorrhage in the obstetric setting.

At 34.4%, Massachusetts has the highest rate of Cesarean deliveries in the US with some birth hospitals having rates as high as 47.4%. There is a growing concern for a concurrent rise in near term births and the long term health impact on these infants and their families. In May 2011, MDPH, March of Dimes, and the MA Chapter of ACOG hosted the 1st Statewide Summit on Perinatal Health and Obstetrical Care. The summit focused on the quality and safety of obstetric care in light of the data demonstrating wide variation in Cesarean delivery rates. Discussion included examining other quality initiatives such as efforts to reduce elective deliveries prior to 39 weeks gestation, and standardizing and improving maternity care.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Perinatal regulations are monitored to ensure women and infants receive the most appropriate care for their medical needs and to reflect current state of practice at Level II and Level III hospitals. | | | | X |
| 2. The Perinatal Advisory Committee (PAC) brings multiple hospital level and professional discipline perspectives to bear on ongoing implementation of the regulations. | | | | X |
| 3. Per the regulations, hospitals collect infant and maternal indicators. Level IIIs must participate in the Vermont Oxford Network, providing NICUs reliable, confidential data for quality management, improvement, internal audit and peer review. | | | | X |
| 4. The Perinatal Data Workgroup functions as a research body that operates under the guidance of a 24AB and will report relevant (aggregated – de-identified) results to the PAC to inform their decision-making/policy development process. | | | | X |
| 5. BFHN and MDPH BHCSQ survey and conduct site visits of hospitals and review compliance with new regulations. | | | | X |
| 6. EIPP, MHVI and other home visiting programs screen for risk conditions and refer to appropriate level of care. | | X | | X |
| 7. Through a variety of mechanisms, MDPH works with communities to use local data on VLBW infants to identify program priorities and policies to address VLBW and preterm birth. | | | | X |

| | | | | |
|---|--|--|--|---|
| 8. An Expert Review Group (ERG), working with BFHN and BHCSQ, reviews and evaluates specific data related to newborns born in Level II maternal and newborn hospitals who require respiratory support - Continuous Positive Airway Pressure (CPAP) or STMV. | | | | X |
| 9. The ERG also reviews and evaluates specific data related to the care and management of newborns 32-33 6/7 weeks born in two Level II hospitals that do not provide CPAP services. Advice from the ERG is used in developing policy. | | | | X |
| 10. | | | | |

b. Current Activities

Level III hospitals and those with an identified concern for the standard of care being provided were prioritized for on-site surveys by BFHN/BHCSQ staff. 45 of 47 active Massachusetts Birth Hospitals and the Boston Children's Hospital NICU had been surveyed and re-designated. In addition, we have also surveyed (just recently) one of two Birth Centers.

The Perinatal Advisory Committee, Perinatal Data Workgroup and ERG continued work on projects that inform DPH on policy and regulatory issues.

Focus areas of concern continue to include the continuing rise in gestational diabetes and cesarean births, disparities in perinatal outcomes, and late preterm and early term births.

MDPH collaborated with the March of Dimes to support the Second Massachusetts Perinatal Quality Collaborative Summit. The goals of MPQC is to improve the perinatal outcomes of Massachusetts residents by quickly identifying and facilitating the adoption of proven, cost effective, evidence based practices at the state's maternity facilities. The MDPH Medical Director presented on late preterm and early term deliveries and maternal morbidity using Massachusetts birth data.

c. Plan for the Coming Year

Continue ongoing activities.

The Perinatal Data Workgroup will continue to work closely with the DPH Privacy and Data Access Office (PDAO) to implement the Perinatal Data Review Project. The goals of the project are to 1) monitor outcomes of mothers and infants over time to measure the success of the revised maternal and newborn hospital licensure regulations in assuring all mothers and infants receive care at a hospital licensed at the appropriate level for their needs and 2) measure whether the regulations help reduce maternal, fetal and infant morbidity and mortality.

In FY 13, DPH will work with the Perinatal Data Workgroup to select 2-3 focused projects, including the review of data to determine the variations in early neonatal deaths of high risk neonates (<28 weeks and <1000gms) in the first 7 days based on birth hospital level of care.

MDPH staff will provide technical assistance as needed in implementing hospital based improvement plans and will assess the ratio of VLBW infants in each Massachusetts region to determine whether an adequate number of NICU beds exist in each region, or that a well functioning system of transfer of VLBW requiring level III services is in place to ensure that high-risk deliveries are managed in these hospitals.

Following up on the first two Statewide Summits on Perinatal Health and Obstetrics Care, a third summit will be convened of public health experts and obstetric providers to continue a dialogue on developing recommendations for standardizing maternity care in all birth hospitals.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|-------------|---------------------|---------------------|---------------------|---------------------|
| Annual Performance Objective | 83 | 82 | 81.5 | 80 | 80 |
| Annual Indicator | 81.4 | 79.6 | 81.0 | 82.9 | 82.5 |
| Numerator | 63408 | 61292 | 60758 | 60346 | |
| Denominator | 77934 | 76969 | 74966 | 72835 | |
| Data Source | | Mass. Vital Records | Mass. Vital Records | Mass. Vital Records | Mass. Vital Records |
| Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 82.5 | 83 | 83 | 84 | 84 |

Notes - 2011

2011 birth data are not available. We have estimated a similar rate to that for 2010. See 2010 for the most recent actual data and see the Note for 20010 for data sources and other comments.

We have modified outyear targets slightly to suggest a modest improvement by 2016.

Notes - 2010

Data are from MDPH Vital Records for calendar year 2010. This is the most recent year of data available.

The percentages shown differ from those published elsewhere, due to how missing data are handled. The MCHB definition of the denominator is specified as all resident births during the referenced year. In MassCHIP and most Massachusetts publications (such as Massachusetts Births), percentages are reported only for cases where information is known (i.e. the denominator excludes births for which data on the variable are missing). Using the MCHB definition reduces the calculated percentage slightly.

Massachusetts has already surpassed the HP 2020 target of 77.9%.

Notes - 2009

Data are from MDPH Vital Records for calendar year 2009.

a. Last Year's Accomplishments

PRAMS data on prenatal care timing and related factors are now being used for ongoing assessment. Counts and percentages for first trimester care have been obtained. The 2007-2008 findings were presented to the PRAMS Advisory meeting in May 2011 and suggestions for the 2009 MA PRAMS Surveillance Report were solicited. A fact sheet using PRAMS data on prenatal

care entry by the first trimester was produced. PRAMS data on prenatal care timing and related factors are now being used for ongoing assessment.

PRAMS data provide useful information about prenatal care utilization including timing of entry into prenatal care and barriers to receipt of prenatal care. In 2010 (the most recent PRAMS data available), 92.7% of MA mothers initiated prenatal care in the first trimester; however, mothers on Medicaid were less likely (87.8%) than non-Medicaid mothers (95.5%) to initiate care in the first trimester. More than 82% of mothers received prenatal care deemed adequate or adequate plus as measured by the Kotelchuck Index. Medicaid women were more likely to receive inadequate or no prenatal care (13.3%) compared with women who had non-Medicaid insurance (6.5%). Women who were white, non-Hispanic (95.2%), aged 30-39 years (95.5%), aged 40 years or above (95.3%), had some college (91.6%), college-educated (96.8%), and had non-Medicaid insurance (95.5%) reached the HP2010 target for early initiation of prenatal care. Reasons for not receiving prenatal care as early as was wanted included the following (not mutually exclusive): didn't know about pregnancy (44.6%), inability to get an appointment (38.8%), doctor or health plan would not start care as early as the mother wanted (19.8%), too many other things going on (16%), couldn't afford it (11.6%), didn't want anyone else to know about the pregnancy (10.3%), couldn't take time off from work or school (9.4%), didn't have a Medicaid card (7%), and no transportation (6.2%).

Massachusetts Pregnancy Nutrition Surveillance (PNSS) 2010 Statewide Summary Data Report (still the most recent available) indicated that 74% of women on WIC entered prenatal care in the 1st trimester. PNSS also indicated that 36.7% of pregnant women enrolled in WIC by the first trimester, an increase from the previous year. WIC's performance management system includes a measure related to early enrollment.

At local WIC program request, a poster emphasizing the benefits of early WIC enrollment was available to all WIC outreach staff.

All WIC clinics track, through quarterly reports, their progress for enrolling prenatal women in WIC in the 1st trimester. WIC outreach coordinators seek appropriate settings and strategies to outreach to women in early pregnancy. The state office works with community coordinators to identify and implement innovative local outreach strategies. Specific strategies to reach the prenatal population early are incorporated into each local programs annual outreach plan.

Table 4a, National Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. WIC, MHVI, and EIPP reach out in communities to pregnant women to encourage early enrollment into their programs, helping to reach women at risk of late entry to prenatal care. | | X | | |
| 2. WIC services statewide refer for prenatal care at first contact with pregnant women. | | X | | |
| 3. EIPP, MHVI, FRESH Start and FOR families programs provide assistance with accessing prenatal care and optimizing health benefits. EIPP has relationships with Managed Care Organizations (MCO's) to reimburse for home-visits to pregnant women. | | X | | |
| 4. BFHN continues to strengthen collaborations with state and community partners to identify and address barriers to getting early prenatal care, for example, local federally-funded Healthy Start programs. | | | | X |
| 5. The state Healthy Start Program administered by MassHealth insures pregnant women not eligible for MassHealth at or below | X | | | |

| | | | | |
|--|---|---|--|---|
| 200% FPL, in order to improve access to early, comprehensive, and continuous prenatal care. | | | | |
| 6. Family Planning and other DPH-programs that include among their clients pregnant teens, as well as others at risk of late entry to care, encourage and help clients access prenatal care as early as possible. | | X | | |
| 7. ODT performs statistical analyses with state birth data to monitor trends and assess populations at higher risk for late entry into prenatal care and related factors. | | | | X |
| 8. WIC disseminates reports to assist programs in tracking progress for enrolling women in the first trimester of pregnancy. Outreach strategies that have proven successful are shared and discussed among program outreach staff. | | | | X |
| 9. MassCARE assures prenatal care to HIV infected pregnant women through community health centers, using an HIV medical home approach that includes case finding and educating other local providers in treatment guidelines for perinatal HIV care. | X | | | X |
| 10. MDPH encourages all programs to take a life-course perspective on health care and programming leading to broad based consideration of preconception and interconception needs for all childbearing aged women. | | | | X |

b. Current Activities

See Summary Chart above.

The 2009 MA PRAMS Surveillance Report was completed and disseminated in May 2012. The findings were presented to the PRAMS Advisory meeting in May 2012. We received the weighted 2010 PRAMS dataset from CDC in March 2012.

See FY11 for data from the 2010 PRAMS surveys.

c. Plan for the Coming Year

Continue ongoing activities.

We plan to produce a 2009-2010 MA PRAMS Surveillance Report. The next PRAMS Advisory meeting will be held in May 2013 to share findings and activities related to first trimester prenatal care entry.

In addition, knowledge gained from the proposed RIM (Review of Infant Mortality) initiative will help both explicate the relationships between late entry into prenatal care and poor pregnancy outcomes and identify strategies to reduce both.

MDPH will continue to seek opportunities to encourage preconception and interconception care as part of taking a life-course perspective on women's health and maternal and child health. In this context, discussing both the need to plan pregnancies, and receive early prenatal care becomes part of any health care discussion with women at each health care or home visit.

One MHVI goal is provide comprehensive evidence-based home visiting services for families prenatal through age 5 in high need communities. A major focus is identifying women early in pregnancy, or prior to conception, and linking them with a wide array of services. MHVI will collect and analyze benchmark data on the number of women entering the program without prenatal care who were successfully linked with services. This data will inform program strategies for successfully enrolling women in prenatal care.

D. State Performance Measures

State Performance Measure 1: *The percentage of pregnancies among women age 18 and over that are intended.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|--|-------------|------------------------------|------------------------------|------------------------------|------------------------------|
| Annual Performance Objective | 76 | 79 | 80.3 | 81 | 83.4 |
| Annual Indicator | 78.4 | 80.3 | 80.3 | 83.4 | 83.4 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | Mass. BRFSS bi-annual survey | Mass. BRFSS bi-annual survey | Mass. BRFSS bi-annual survey | Mass. BRFSS bi-annual survey |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 83.5 | 83.5 | 84 | 84 | 85 |

Notes - 2011

There are no updated data for 2011. The data for this measure are available every other year from the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS). The 2011 estimate is from the 2010 survey data.

Notes - 2010

The data for this measure are available every other year from the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS). The 2010 estimate is from the most recent BRFSS in 2010. See the Detail Sheet (in Form 16) for this measure for definitions, data source and issues, and a discussion of its significance.

Our projected target rates have been raised slightly based on the continued improvement shown in the 2010 survey.

Notes - 2009

There are no updated data for 2009. The data for this measure are available every other year from the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS). The 2009 estimate is from the 2008 survey data.

a. Last Year's Accomplishments

See also NPM #8 and additional information under Priority Need # 5 in the Attachment to Part 4F.

Family planning services funding decreased by another 1.25% in FY11 to \$4.47M due to state budget cuts. Although this was the smallest reduction in several years, the cumulative effect of many years of budget reductions has forced many family planning agencies to consolidate their funding into clinical services and away from community education and outreach efforts.

The "Choosing a Birth Control Method" fact sheet and brochure series continues to be available online at www.maclearringhouse.com and has been distributed for use in a variety of health care and educational settings. Over 18,785 brochures were distributed in FY11.

The "Where can I get Plan B?" flow chart was updated to reflect the lowered age limit and remains downloadable on the Clearinghouse website. It provides information about what to do if one has had unprotected sex in the last five days. Action steps are described and MA resources are provided about how to obtain emergency contraception.

The formal process of monitoring the 74 acute care hospitals for compliance with the Emergency Contraception regulations was completed. All of the hospitals' policies for serving sexual assault survivors were deemed in compliance with the regulations. The EC legislatively mandated fact sheets were revised to include the newly approved method Ella.

Because of the increased risk of unintended pregnancy among women experiencing domestic violence, the Family Planning Program continues to prioritize the integration of violence and reproductive coercion screening into the family planning encounter. Incorporation of violence screening and referral is assessed at all comprehensive site reviews of MDPH-funded family planning programs. Two agencies received comprehensive reviews in FY11 and it was noted that violence screening was integrated into the medical history forms and performed consistently.

In FY12, the Family Planning Program will competitively bid family planning funds (for services beginning in FY13) for the first time since FY06. Initial data gathering and needs assessment activities were completed in 2011, including structured activities for existing providers to contribute feedback on the procurement structure and program standards, particularly in light of health care reform.

In FY11, BFHN perinatal programs continued to focus education on reproductive life planning for all women of childbearing age, with emphasis on preconception and interconception care within home-based and center-based programs; they consistently provide family planning information to postpartum women. Staff from EIPP, FRESH Start, MHVI and other home-visiting programs are trained to provide reproductive life planning for project participants, and continue to use materials developed through the HRSA-funded MA New Parents Initiative to provide emotion-based messaging on family planning.

The Family Planning Program produced agency-specific data reports using agency submitted annual report data from FY2007 through FY2010. These reports compared individual agencies to all statewide agencies combined on a variety of family planning service provision data points. Reports were shared with funded agencies. These reports were also used to create a program factsheet.

BFHN released the first PRAMS (Pregnancy Risk Assessment Monitoring System) report for MA, combining 2007 and 2008 data gathered from recently delivered women and infants in MA.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Comprehensive clinical reproductive health care, community education and outreach are provided through a statewide family planning provider system. | X | | | |
| 2. Reproductive health services are also provided through School Based Health Centers, and ESHS programs. | X | | | |
| 3. Family Planning and perinatal programs participate in planning | | | | X |

| | | | | |
|--|---|---|---|---|
| and national, state and local collaborations to assure continued availability of basic reproductive health care. | | | | |
| 4. Family Planning standards are set by MDPH; programs are monitored for adherence, including vendor site assessments and technical assistance. | | | | X |
| 5. MHVI, FRESH Start, FOR Families & EIPP home visitors assess women for FP information and make follow-up referrals to family planning or primary care. MIECHV has a measure for preconception care, collecting and analyzing data on all participants. | | X | | |
| 6. Increase access to emergency contraception and sexual health services through a statewide website and hotline, and inclusion of EC information and protocols in all sexual assault evidence collection kits. | X | X | | X |
| 7. Collaborate with BSAS in substance abuse prevention and services (including those for youth). | | | X | X |
| 8. Improve surveillance of women of reproductive age through implementation of PRAMS, as well as questions already included in the BRFSS every two years. | | | | X |
| 9. Maintain statewide website and sexual health hotline Maria Talks. | | X | | X |
| 10. Train and support Family Planning providers to screen for and respond to intimate partner violence and sexual assault. | | | | X |

b. Current Activities

See also NPM #8 and additional information under Priority Need # 5 in the Attachment to Part 4F.

In preparation for the Request for Responses (RFR), the Family Planning Program completed online surveys of community stakeholders and youth on the future of family planning activities, particularly in light of health care reform. The new RFR was developed and released in February 2012, with new vendors contracts' to begin in FY13.

Following a mass mailing of the revised legislatively mandated EC fact sheets, several hospitals submitted updated policies and requested technical assistance to ensure continuing compliance with the EC regulations.

MDPH program staff continue to provide training on violence screening in family planning settings, and MDPH-funded family planning providers have requested additional training on this topic. MDPH continued to work with JSI (the Title X Region I family planning regional training provider) and BARCC (the Boston-Area Rape Crisis Center, which also operates a training center with a state and national reach) to assess existing curricula on violence screening in family planning settings and propose next steps for the institutional development of training capacity in this area.

c. Plan for the Coming Year

Continue ongoing activities. See also NPM #8 and additional information under Priority Need # 5 in the Attachment to Part 4F.

State funding for family planning is expected to remain at FY12 levels; reductions in federal MDPH funding lines are anticipated. These reductions, compounded by reductions in each of the last four fiscal years, will have significant impacts on the scope of services that the MDPH-funded family planning agencies can provide.

The new contracts resulting from the Family Planning Program RFR will start July 1, 2012. The goals of the program are to: 1) decrease the number of unintended pregnancies in Massachusetts and 2) decrease the incidence of sexually transmitted conditions in Massachusetts. The program intends to affect behaviors that influence these goals through the strategic combination of clinical and non-clinical efforts to priority populations and communities. These efforts will include clinical services, education and technical assistance, outreach and clinical wraparound services. Technical assistance and training needs of new providers will be assessed and appropriate training provided throughout FY 13. Site visits are planned with all new contracted vendors.

New family planning vendors will also be surveyed regarding health education and outreach material needs. Hospital needs for EC materials will also be assessed.

In accordance with the newly expanded program focus, a new program evaluation and monitoring plan will be implemented beginning in FY13 which will include new contract performance measures and revised reporting mechanisms. These have been created to reflect the priorities laid out in the program's logic model.

Violence screening and prevention activities will continue with anticipated collaboration from local community based organizations and the federal Title X program.

The MA New Parents Initiative (MNPI) will continue to conduct provider orientations using the digital stories and the toolkit and providing information on how providers can communicate family planning topics more effectively with their clients. All materials developed are available at www.mass.gov/dph/newparents. And, since the funding for the original grant has ended, BFHN will seek additional support to continue producing these materials. These materials, and other materials that are being developed to augment the MNPI materials, will be provided to all families giving birth in 17 high need communities through a voluntary universal one-time home visit.

MHVI will continue to provide training to all home visitors on integrating and supporting preconception and interconception care education with a focus on developing a reproductive life plan. MDPH staff will provide technical assistance on using materials and information developed through the Department.

State Performance Measure 2: *Development and Implementation of Social Connectedness Measures across the Lifespan for Three Population Groups.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|--|-------------|-------------|-------------|----------------------------|----------------------------|
| Annual Performance Objective | | | | | 1 |
| Annual Indicator | | | | | 2 |
| Numerator | | | | | 2 |
| Denominator | | | | | 20 |
| Data Source | | | | Title V program assessment | Title V program assessment |
| Is the Data Provisional or Final? | | | | | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance | 2 | 8 | 12 | 19 | 20 |

| | | | | | |
|-----------|--|--|--|--|--|
| Objective | | | | | |
|-----------|--|--|--|--|--|

Notes - 2011

This is a new measure – one which replaces a previous temporary one whose purpose was to develop a permanent MCH State Performance Measure related to social connectedness across the lifespan. That goal was accomplished during FY11. The new measure, which is a Checklist with a maximum possible score of 45, is shown as an attachment to the “Last Year’s Accomplishments” subsection of the narrative for this Measure.

The measure was scored by Title V program staff assessments of activities and the progress of a working group during FY11 and FY12. Scoring projections for FY12-FY16 were also developed. See Notes to Form 16 (Detail Sheet) for details on components and scoring. See the Detail Sheet (in Form 16) for the measure for definitions and discussions of its significance and development.

Because we cannot change the Annual Performance Objective for FY11 in TVIS, the value shown (1) refers to the initial measure scoring; it should read as “2.” Because the TVIS software also cannot support a total scale score of more than 20, the display of the 2011 denominator is not accurate and should be 45; the numerator is correct. The Annual Indicators for 2012 – 2015 are shown correctly. However, the Annual Indicator for 2016 is 25, not 20.

Notes - 2010

A new, final measure was developed as planned. Because we cannot enter a non-numeric response of “YES,” we have used “1” instead to indicate success.

a. Last Year's Accomplishments

See also Priority #2, NPM#16 SPM#5, and SPM#9

In the process of conducting the 2010 five year needs assessment, there was consensus within the Department of Public Health (DPH) across multiple bureaus and programs and with external stakeholders that a priority specifically addressing emotional wellness and social connectedness across the lifespan should be included to reflect the extensive work of the agency in: 1) addressing policies that promote social connectedness; 2) collecting and analyzing data specific to emotional wellness and social connectedness; 3) establishing partnerships to facilitate communication and informing strategies for promoting emotional wellness and social connectedness for women and infants, children and youth including those with special health care needs; 4) promoting family support and access to care; 5) developing workforce capacity to ensure competency of multidisciplinary providers; and 6) promoting awareness that behavioral health is an integral component of overall health for women and infants, young children, youth and their families. This measure represents the result of those discussions.

See the attachment to this section for the scoring of the new measure checklist.

DPH staff were directly involved with a number of key state-systems building initiatives designed to support the social emotional wellness of children and their families. The Director of the Bureau of Family Health and Nutrition serves as the Commissioner's representative on the Executive Office of Health and Human Services' (EOHHS) Children's Behavioral Health Initiative (CBHI) Executive Committee and as a member of the CBHI Implementation Coordinating team. CBHI is an interagency initiative whose mission is to strengthen, expand and integrate Massachusetts services into a comprehensive system of community-based, culturally competent behavioral health and complementary services for children with serious emotional disturbance and other behavioral health needs.

In FY11, in response to the postpartum depression legislation signed into law in August 2010, the

Department convened an expert working group that advised the Department in developing and disseminating Standards for Effective PPD Screening, Recommendations for PPD Data Reporting, a PPD screening tool grid and an extensive resources list. The MCH Director was appointed to be part of the Commission, and other staff participate actively in sub-committees of the Commission.

To increase capacity to collect and analyze data, MDPH continued to support the use of standardized screening for maternal depression and early childhood social-emotional wellness by home-visiting programs.

DPH staff continued to train a wide range of providers including pediatricians, home visitors, community health workers, ob/gyns, midwives, nurses and other staff at community health centers and within home visiting programs in the use of the Massachusetts New Parents Initiative (MNPI) bag and other items in the provider tool kit. Once trained, providers were then able to order additional materials to use with the new parents with whom they work.

Early Intervention (EI) programs provide a range of services to young children, including addressing mental health and emotional well-being. Specific emphasis within all early intervention services focuses on parent/child attachment. Additionally, all EI providers offer assistance to parents and family members of enrolled children who may be seeking or are in need of mental health services. In FY 10, 88.1% (2,264) of the children in the Massachusetts EI System (excluding those eligible due to at risk only) who entered the program substantially increased their rate of growth in the area of social/emotional skills at the time of exiting EI services.

In addition, 89.7% (5,390) of children in EI with a developmental delay (regardless of type of delay) demonstrated improved functioning in the acquisition and use of knowledge and skills (communication domain) and 93% (4,096) demonstrated improved functioning in the use of appropriate behaviors to meet their needs (adaptive/self help domain).

LAUNCH and MYCHILD, two Early Childhood Mental Health (ECMH) system of care grants administered through a Massachusetts-Boston partnership, teamed up with EEC to support the statewide rollout of the CSEFEL Pyramid Model of promoting social and emotional competence and addressing challenging behavior in young children.

An attachment is included in this section. IVD_SPM2_Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Develop plan to expand CBHI services birth to 5 years including training and hiring early childhood mental health providers. | | | | X |
| 2. Support Postpartum Depression legislation by convening an advisory committee to develop standards for measuring and reporting data and issuing regulations, policies and resources to support implementation. | | X | X | X |
| 3. Support anti-bullying legislation by developing materials and providing training and technical training support to schools on creating inclusive, safe, supportive and healthy environments. | | | X | X |
| 4. MHVI, EI, EIPP, FRESH Start, Care Coordination and other MDPH home visiting programs and school-based health centers routinely screen and assess for social emotional health and social connectedness and are inclusive of all family members. | | X | | |
| 5. Use standardized and evidence-based screening tools and protocols for identifying early childhood social-emotional | | X | X | |

| | | | | |
|---|--|--|--|---|
| wellness and maternal depression. | | | | |
| 6. Participate in key stakeholder collaborations including CBHI, PPD legislative commission and advisory committee. | | | | X |
| 7. Develop workforce capacity by supporting training which includes trauma informed care for school nurses, early childhood providers, home visitors and providers. | | | | X |
| 8. Develop and use standard language to promote consistent messaging on social emotional health and social connectedness across programs and state agencies. | | | | X |
| 9. Develop social marketing materials on maternal-infant mental health, early childhood emotional health, and adolescent emotional health in multiple languages and representing diverse populations. | | | | X |
| 10. | | | | |

b. Current Activities

See also Priority #2, NPM#16 SPM#5, and SPM#9

BFHN shared the tool developed for measuring emotional wellness and social connectedness across the lifespan at the individual and systems levels with MDPH staff and used this as a priority focus for multiple programs including MHVI, FRESH Start, EIPP and other home-visiting programs.

Massachusetts successfully competed for two major federal grants with a strong focus on ECMH: a MIECHV expansion grant and a Race to the Top - Early Learning Challenge Grant (together totaling close to \$100M).

MDPH, in collaboration with Brandeis University, sponsored a health policy forum entitled "Substance Exposed Newborns: Addressing social costs across the lifespan."

To increase capacity to collect and analyze data, MDPH supported home-visiting programs use of standardized screening for maternal depression and early childhood social-emotional wellness.

The MDPH Early Intervention Training Center (EITC) is currently working with the Connected Beginnings Training Institute to create an online training module to support infant and early childhood social emotional well-being. This training will be launched and available to early childhood clinicians in FY13.

LAUNCH/MYCHILD launched a new website in March 2012 (ECMHmatters.org) that promotes the Mass LAUNCH and MYCHILD models and highlights various ECMH systems change activities. The site also provides families with information and resources through links to other local, state and national organizations.

c. Plan for the Coming Year

Continue ongoing activities. See also Priority #2, NPM#16, SPM#5, and SPM#9

DPH and the EITC will continue to provide training opportunities in early childhood emotional health, including "Social/Emotional Development, Screening and Practical Applications of Screening Tools in Early Intervention." This training focuses on the relationship between parent(s)/caregiver(s) and the developing child from birth to age three. DPH staff will continue to develop a training curriculum that will provide strategies and resources for staff to integrate Federal Child Outcomes into the IFSP process.

LAUNCH will partner with the state's DHCD Housing Stabilization program to address homeless

family needs regarding early childhood mental health (ECMH). As part of MHVI, LAUNCH will participate as a collaborating program in a new effort to maximize the reach and effectiveness of perinatal and early childhood home visiting in Boston. This effort will enable the participant programs to target resources based on family need, develop clear, shared criteria for referral, and engage in shared activities around staff training and community outreach.

The new Race to the Top Early Learning Challenge Grant (ELCG) includes a strong focus on interagency collaboration to support early childhood systems. Under the ELCG, DPH will partner with EEC and other state agencies on several aligned initiatives to support the social emotional health of young children. Supported by ELCG, DPH will hire an ECMH clinical specialist to provide technical assistance to EEC across a number of domains including child care licensing and policy development as well as support to staff, vendors and consumers on promotion of social emotional development and prevention and intervention with young children who exhibit behavioral and mental health concerns.

DPH staff will continue to work with the expert working group on the regulations and the web page on the Department website as required by the PPD legislation. A Bureau staff member has been appointed as the DPH representative to the commission advising on implementing the law.

MHVI will collect data on maternal and infant mental health, as well as and ECMH, including positive social-emotional skills (including social relationships) and use of appropriate behaviors to meet one's needs. In addition, all staff will be trained in screening and response for maternal, infant and child mental health. MHVI will also implement an evidence-based program, Parents Together, for promoting social connections and supporting emotional health among participants.

The SBHC Program is beginning a new funding cycle and will train all clinical providers in methodologies related to conducting assessments of risk and resiliency behaviors in adolescents. Resiliency factors include 'school connectedness' as defined by the CDC. Clinicians will also screen students for the presence of a 'trusted adult' defined as 'someone they can confide in and/or obtain emotional support from'.

State Performance Measure 4: *The percentage of women with a recent live birth reporting that they had their teeth cleaned recently (within 1 year before, during, or after pregnancy).*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---------------------------------------|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | | | | | 73.1 |
| Annual Indicator | | 77.7 | 71.4 | 75.1 | 75 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | Mass. PRAMS | Mass. PRAMS | Mass. PRAMS | Mass. PRAMS |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 75 | 75.5 | 75.5 | 76 | 76.5 |

Notes - 2011

Data Source: Massachusetts PRAMS. 2011 PRAMS data are not yet available. We estimated a rate based on 2009 and 2010 data.

Notes - 2010

Data Source: Massachusetts PRAMS. 2010 PRAMS data. Because PRAMS results are reported as estimates based on weighted survey data, only the percent is be reported, without numerators and denominators.

Notes - 2009

Data Source: Massachusetts PRAMS. 2009 data. Because PRAMS results are reported as estimates based on weighted survey data, only the percent is be reported, without numerators and denominators.

a. Last Year's Accomplishments

MA PRAMS continued its data collection activities and produced the 2007/2008 surveillance report in September 2010. The oral health questions included on the MA PRAMS survey allow us to better estimate the rates of dental cleaning among pregnant women before, during, and after pregnancy.

As part of the initiative to improve oral health care during pregnancy, a PRAMS intern conducted analyses using the 2007-2009 PRAMS data to examine the risk factors associated with low rates of oral health screening among pregnant women in MA and explore the association between oral health and pregnancy outcomes. In addition, the intern conducted a literature review about current research, best practices, and state and national initiatives around perinatal oral health care. Using this information and more descriptive analyses, we identified the groups of women who were less likely to have had their teeth cleaned before and/or during pregnancy.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Remain engage with the MA Perinatal Quality Collaborative to include oral health as a priority for discussion at the next MPQC Summit . | | | | X |
| 2. Develop evidence-based oral health guidelines for prenatal providers. | | | | X |
| 3. Integrate oral health into the medical schools' curricula. | | | | X |
| 4. Use the Smiles for Life Pregnancy Module for presentations. | | | | X |
| 5. Analyze and disseminate the results of the oral health surveys to Massachusetts physicians and dentists and get their feedback. | | | | X |
| 6. Work with oral health champions to implement an oral health referral process for pregnant women using Dr. Silk's referral form as a template. | | | | X |
| 7. Develop an oral health during pregnancy fact sheet for physicians and dentists. | | | | X |
| 8. Develop a patient education handout on preconception and prenatal oral health care. | | | X | X |
| 9. Conduct series oral health presentations at the Yankee, MA ACOG meeting and in the six regions of the state. | | | | X |
| 10. | | | | |

b. Current Activities

To gain a better understanding of the relationship between oral health care in pregnancy and maternal health and pregnancy outcomes in MA, MA PRAMS conducted a survey of physicians and dentists to assess knowledge and practices/treatments during pregnancy, and to describe

referral patterns and barriers to care among pregnant women and providers. Findings from the oral analyses were presented at the 17th MCH Epidemiology Conference in December 2011.

These findings were also presented at four medical/dental/public health schools in MA: Tufts University, Boston University, University of Massachusetts (UMass) Medical School, and Harvard University. The presentation focused on the statistics of oral health during pregnancy, the research behind perinatal oral health care and pregnancy outcomes, and the imperative to improve the rates of screening among pregnant women, and referrals between physicians and providers for oral health services delivered during pregnancy.

These presentations were well received by both students and faculty. Dr. Hugh Silk MD, MPH, a faculty member at the UMass Medical School, indicated that UMass was the only medical school in MA with an oral health curriculum. He tries to reach out to the other medical schools with very little response. Dr. Silk would like to create a universal referral form between medical and dental providers. Dr. Silk also referred us to another physician at Harvard who is trying to champion the cause there.

c. Plan for the Coming Year

See also NPM #9, Continue ongoing activities.

An oral health champion, Dr. Sunah Hwang, identified during the PRAMS Advisory Committee meeting in May 2012, will work collaboratively with the PRAMS Director, the March of Dimes, and members of the newly created MA Perinatal Quality Collaborative (MPQC) to include oral health as a priority topic for discussion at the next MPQC Summit, which is to be held in December 2012. Findings from the physicians and dentist surveys data will be used to highlight the need for perinatal guidelines around screening for oral health in MA. Currently the MA Health Quality Partners Perinatal Care Recommendations do not include dental counseling or examination by the perinatal providers. MA PRAMS plans to work with the MPQC to develop evidence-based oral health guidelines for prenatal providers similar to those developed by New York state and the California Dental Association.

The Association of American Medical Colleges is working on a new curriculum for medical students that will be launched this summer. This will be an opportunity to re-engage the medical schools in Massachusetts.

The PRAMS team has also reached out to Dr. Inyang Isong, a pediatrician who is working with the Harvard Dental School to integrate more oral health into the Harvard Medical School curriculum.

The PRAMS team will continue to work with ACOG in collaboration with Dr. Silk on a series of presentations at the Yankee Dental Congress, the MA ACOG annual meeting, and perhaps 6 regional presentations for CME credits. The presentations can use the Smiles for Life Pregnancy Module and introduce the referral form Dr. Silk created and is using in his practice. Other materials that MDPH has - perhaps a one page laminated "how to take care of your pregnant patients from a dental stand point" could also be used. Dr. Silk also hopes to take this to each OB/GYN and family medicine residency program.

MA PRAMS staff plan to submit an abstract to the annual American Public Health Association meeting. PRAMS findings will be used to translate data into patient and provider educational and informational materials. The prenatal care and dental provider's surveys will be analyzed. Research done in the next year will continue to shape interventions and future oral health initiatives. These data can also be used to inform outreach by community organizations such as

WIC to increase awareness about the lack of oral health care during pregnancy and the importance of maternal oral health for the health of the infant.

Deliverables created from data analysis will include a fact sheet aimed at providers, and patient education pamphlets that offer information and tips for oral health care before, during and after pregnancy.

MHVI staff will receive training as part of their core competency in linking families prenatal -- age 8 to a dental medical home. EIPP will continue to refer pregnant and parenting (up to one year) women to dental services including to dental medical homes.

State Performance Measure 5: *The percentage of School Based Health Center clients for whom an assessment for intimate partner/teen dating/sexual violence was done.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|--|-------------|-------------|------------------|------------------|------------------|
| Annual Performance Objective | | | | | 32 |
| Annual Indicator | | | 28.3 | 30.5 | 28.9 |
| Numerator | | | 3179 | 3022 | 2769 |
| Denominator | | | 11215 | 9914 | 9592 |
| Data Source | | | MA SBHC database | MA SBHC database | MA SBHC database |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 30 | 50 | 60 | 70 | 75 |

Notes - 2011

Data Source: Massachusetts School Based Health Center database. The data reflect only those enrolled SBHC clients age 13 and above. Beginning in FY13, one of the contract performance measures for the newly procured SBHC contracts requires that "75% of SBHC clients age 11 years or older seen by the medical provider (physician, nurse practitioner, physician's assistant) will be assessed at least once during the school year for healthy relationships and receive an intervention". These assessment data will be reported to MDPH on a bi-annual basis and will be instrumental in determining contract compliance/performance. Therefore future reporting will be against different criteria. We have set progressively higher targets, with the goal of 75% compliance by all sites by 2016.

Notes - 2010

Data Source: Massachusetts School Based Health Center database. The data reflect only those enrolled SBHC clients age 13 and above.

Notes - 2009

Data Source: Massachusetts School Based Health Center database.

New State Measure, so no projections until 2011

a. Last Year's Accomplishments

Throughout FY11, the SBHC Program has continued to assess students for intimate partner/dating violence with the goal that data from FY10 and FY11 will serve as baseline data for comparison once more comprehensive assessment practices are implemented during the coming year.

In FY11, 26.64% of the 10,886 SBHC users were assessed for intimate partner/dating violence. Of those assessed, 11.62% were found to be at risk. Looking only at the 9,592 users age 13 and above (the definition used in the reported data), 28.87% were assessed and 10.55% of those were found to be at risk. Overall, the percents found to be at risk were slightly higher than in FY10.

A Dating Violence grant continued by securing an additional year of funding from the CDC. In FY11 the Teen Dating Violence Team revised statewide guidelines to school districts on teen dating violence, taking into account current context of Title IX and related civil rights, new TDV, bullying, wellness and restraining order legislation and regulations in MA that are promulgated by the Department of Elementary and Secondary Education. The new guidelines were publicized through their website.

The "team" also worked with MA PREP (the new federal teen pregnancy prevention initiative) and other Department-supported youth-serving programs to assess and adapt evidence based curricula and/or provide staff training to increase their capacity to integrate trauma-informed, GLBT-inclusive, healthy relationships/sexuality content (including TDV and sexual violence prevention) into their work and settings.

The Sexual Assault Prevention and Survivor Services Unit within DVIP convened an Anti-Trafficking Group in FY11, focused on trafficking-related public health issues and resources. This work included coordination with Essential School Health and School Based Health Centers.

The teen pregnancy prevention program continued to provide training to its providers. In partnership with the DVIP program, the OAHYD offered training in trauma informed care to support teen pregnancy prevention providers in increasing their capacity to work with youth who have experienced physical, sexual and emotional trauma. The OAHYD provided a second level of training to teen pregnancy prevention providers working with GLBTQ youth that addressed the prevention of health risks and promotion of healthy outcomes of this population.

The Teen Dating Violence Prevention Team coordinated by DVIP was merged with the State Sexual Violence Prevention Team to form the State Sexual and Teen Dating Violence Prevention Team which continues to work to implement sexual and dating violence prevention strategies. This Prevention Team also serves as a working group of the Governor's Council Addressing Sexual and Domestic Violence and presented to this body during FY11.

WIC

The Massachusetts WIC Nutrition Program screens for intimate partner violence among all women served at 35 WIC programs statewide. In addition, a general overview of domestic violence is incorporated into all WIC new staff training.

Local WIC programs have developed ongoing relationships with their local community-based domestic violence program and a standard on the Management Evaluation (ME) will monitor annual domestic violence trainings at the local WIC Programs.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. The SBHC Program participates in planning clinical staff development activities related to current IPV trends for | | | | X |

| | | | | |
|--|--|---|--|---|
| adolescents (including social media-related IPV/sexting/bullying). | | | | |
| 2. The SBHC Program offers training on healthy relationship-skill building for adolescents (aimed at preventing intimate partner violence and enhancing resilience). | | | | X |
| 3. The SBHC Program participates in planning widespread dissemination of “Boys into Men” curriculum for primary violence prevention. | | | | X |
| 4. The SBHC Program convenes local rape crisis centers and requires formal collaboration with their local school-located clinics. | | X | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The Program has just completed a competitive bidding process to award new contract funding. One of two areas of focus in the recent RFR was ‘adolescent relationship abuse’.

The State Sexual and Teen Dating Violence Prevention Team completed work with DESE to propose revisions and additions to DESE statewide guidelines to school districts on teen dating violence, taking into account current context of Title IX and related civil rights, new TDV, bullying, wellness and restraining order legislation and regulations in MA. These revisions are currently under DESE legal review. The team also continued to work with MA PREP (federal teen pregnancy prevention initiative, a collaboration between DPH and DESE) to assess and adapt evidence based curricula and provide training to increase integration of trauma-informed, GLBT-inclusive, healthy relationship/sexuality content including TDV and sexual violence prevention.

Through the Anti-Trafficking Working Group, a working group was formed on school-based initiatives, which developed model protocols and training for school nurses on assessment and response regarding trafficking and sexual exploitation of youth. The group coordinates with the new legislatively-based state Anti-Trafficking Task Force established in FY12. Additional web-based training is planned for FY13.

See Priority # 4 in the Attachment to Section IV.F. for details on these and other prevention of violence activities.

c. Plan for the Coming Year

Continue on-going activities.

The SBHC Program has designated Adolescent Relationship Abuse (ARA) as a special area of focus for the duration of the new funding cycle. The funding specifications included the following:

SBHC clinicians will be mandated to attend an MDPH-sponsored training to be conducted by Elizabeth Miller M.D. using an evidence-based curriculum (H.E.A.R.T.) that was developed collaboratively with Futures without Violence to improve their assessment skills for the early identification of adolescent relationship abuse (ARA). SBHC clinicians will receive specific training including scripted brief interventions to help ask precise questions about controlling behaviors, coercion and birth control sabotage. They will also be trained to use harm reduction strategies

and brief interventions in their routine care of these students.

Specific protocols to be implemented require that students requesting pregnancy testing, emergency contraception and STI testing will be systematically assessed for reproductive coercion and safety. SBHC clinicians will be required to collaborate with their local rape crisis centers and domestic violence programs to ensure that students 'at risk' are referred for necessary services.

One of the contract performance measures for this funding period requires that "75% of SBHC clients age 11 years or older seen by the medical provider (physician, nurse practitioner, physician's assistant) will be assessed at least once during the school year for healthy relationships and receive intervention". Repeated assessments will be ongoing to monitor changes. The assessment data will be reported to MDPH on a bi-annual basis and will be instrumental in determining contract compliance.

There is also a funding requirement that universal education on healthy relationships be integrated into routine adolescent care in all SBHCs. This will be aimed at increasing adolescents' knowledge of healthy relationships, shifting attitudes about what constitutes abusive behaviors, and learning strategies to reduce harm. Additionally, all adolescents will receive pocket guides (produced by Futures without Violence) that include safety tips and violence-related resources.

DVIP staff continue to work with other DPH programs to develop program-specific screening tools and policies that incorporate trauma-informed care. Strategies are being developed for ongoing work with family planning providers, substance abuse treatment providers and home visitors. In addition, DVIP staff are currently convening a Department-wide Healthy Relationships/Healthy Sexuality Working Group to address how DPH programs could - in a more consistent and coordinated manner - screen on substance abuse, violence, depression, HIV, and mental health, possibly by developing an integrated DPH screening tool.

State Performance Measure 6: *Data-driven promotion of healthy weight, physical activity and nutrition for 3 populations: children ages 0-5, children and youth ages 6-17, and women of reproductive age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|--|-------------|-------------|-------------|--------------|--------------|
| Annual Performance Objective | | | | | 15 |
| Annual Indicator | | | | 15 | 25 |
| Numerator | | | | 15 | 25 |
| Denominator | | | | 26 | 20 |
| Data Source | | | | Title V prog | Title V prog |
| Is the Data Provisional or Final? | | | | | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 20 | 20 | 20 | 20 | 20 |

Notes - 2011

This is a revised measure – one which replaces a previous temporary one whose purpose was to develop a permanent MCH State Performance Measure related to healthy weight. That goal was accomplished during FY11 (see the Note for 2010 for more about the temporary measure. The new measure, which is also a Checklist with a maximum possible score of 60, is shown as an attachment to the "Last Year's Accomplishments" subsection of the narrative for this Measure.

The measure was scored by Title V program staff assessments of activities and the progress of a working group during FY11 and FY12. Scoring projections for FY12-FY16 were also developed.

See Notes to Form 16 (Detail Sheet) for details on components and scoring. See the Detail Sheet (in Form 16) for the measure for definitions and discussions of its significance and development.

Note that the FY11 denominator for the old measure (20) was already entered into TVIS, along with the FY11 Objective for it (15); please ignore those numbers. The denominator for FY11 should be 60 and the Annual Performance Objective should be 25. In addition, we cannot enter the new targets for FY12 – FY16, as they are higher than 20. The new targets are in fact, 27, 31, 39, 46, and 53 respectively for FY12 – FY16.

Notes - 2010

This new and temporary measure is scored from a Checklist that includes four components (most with several subcomponents). The components are: 1) Landscape; comprehensive review of current activities/strategies; 2) Partnership/Collaboration; 3) Public Health/MCH Strategies – Identify gaps and best practices; and 4) Develop MCH State Performance Measure related to healthy weight.

Each subcomponent is scored on the scale of 0 = Not started; 1 = In process; and 2 = Complete; the maximum total score is 26. The Checklist itself, with the FY10 scoring by component shown, is provided as an Attachment to the “Last Year’s Accomplishments” sub-section of the narrative for this Measure. See the Detail Sheet (in Form 16) for this measure for definitions and discussions of its significance and development.

Note that the scoring is actually for FY10 and FY11 combined, as the goal of the temporary measure – to develop a permanent healthy weight measure – was accomplished during FY11 and this measure will be retired after this application. The new measure, which is also a Checklist, is shown as an attachment to the “Plans for the Coming Year” subsection of the narrative for this Measure.

The measure was scored by Title V program staff assessments of activities and the progress of a working group during FY11.

Scoring for FY11-FY15 is shown as unchanging as we intend to deactivate this measure with our next application. Outyear projections will be provided for the new permanent measure.

a. Last Year's Accomplishments

A new Healthy Weight Measure was developed with leadership from BFHN. Representatives with expertise in SBHCs, Mass in Motion, gestational diabetes, PRAMS, vital statistics, WIC, breastfeeding, and EI, helped formulate a data-driven, evidence-based approach to promoting healthy weight across the MCH population in MA. Identification of existing data and or new data sources that inform the new measure and current departmental and statewide activities to address the growing rate of overweight and obesity were the focus of these meetings.

The Essential School Health Service Programs surveyed its 72 districts on their nutritional environment: 38.1% had nutrition/physical activity support groups, with 72 monthly meetings attended by 372 students 107 staff, and 12 parents in an average month; school nurses averaged 251 presentations on fitness/nutrition/wellness, with 6,663 students, 1975 staff members and 183 parents attending. School nurses in 154 districts (73 ESHS and 66 partner districts, six charter school districts, and two collaboratives) met these criteria for one or more grade levels, for a total of 174,800 students. Nurses in 104 districts met the screening criteria for all four grade levels.

The financial collaboration between Early Intervention Partnership Program (EIPP) and two of four Massachusetts Managed Care Organizations (MCOs) remains strong with the MCO's reimbursing EIPP providers directly for home visiting and group services to improve the health and well-being of pregnant and post partum women and their infants.

EIPP developed formal linkages with medical providers and birthing hospitals, ensuring continuity of care for all participants. EIPP provided comprehensive health assessments to 561 pregnant and postpartum women, with 61% reporting inadequate food or clothing on intake. EIPP provided education to women on healthy weight and nutrition during pregnancy and postpartum. Health

education highlighted the issue of attaining and maintaining a healthy weight and breastfeeding to benefit both postpartum weight loss and infant health.

The Nutrition Division released trend data by race/ethnicity, age and WIC clinic site for overweight/obesity for children and women through the PedNSS system annual data reports.

The Nutrition Division collected and provided pre-pregnancy BMI and maternal weight gain data through the PNSS system annual data reports and trend data by race/ethnicity, age and WIC clinic site for breastfeeding initiation and duration through PedNSS. The Nutrition Division collaborated with researchers on a USDA-funded grant to examine the relationship between WIC participation, food security and health outcomes, including weight status utilizing nine years of PedNSS and PNSS data.

WIC developed a system of data reporting utilizing the newly implemented Eos system. Highlights related to this measure include breastfeeding initiation and duration reports as well as WIC health/nutrition risk factor reports.

The Nutrition Division launched a breastfeeding social marketing campaign on print, radio and transit, designed to improve awareness of the WIC program as a resource for breastfeeding support. WIC clinician packets, distributed annually to pediatricians, family medicine physicians and nurse practitioners, contain information regarding WIC efforts/strategies/benefits aimed at promoting a healthy weight. A pilot series of supermarket tours was conducted with WIC participants in Franklin/Hampshire/North Quabbin counties to improve utilization of the WIC checks and the cash value voucher for fruits and vegetables.

Local WIC programs received site specific data on breastfeeding, weight status and pregnancy weight gain. Targets related to childhood obesity, breastfeeding and pregnancy weight status were included in the Division's score card, updated quarterly and shared internally. Local programs set targets for breastfeeding initiation and duration at 3 and 6 months. Data was provided to local programs on a quarterly basis to monitor progress towards targets.

PRAMS collected data on pre-pregnancy BMI, physical activity and fruit and vegetable intake in the third trimester of pregnancy, breastfeeding initiation and up to eight weeks. These data were shared with WIC.

See the attachment to this section for the scoring of the new measure Checklist.

An attachment is included in this section. IVD_SPM6_Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Formulate an evidence-based approach to promoting healthy weight across the maternal and child health population in MA in collaboration with internal and external stakeholders. | | | | X |
| 2. Generate BMI data among children 10-17 years using current NSCH data. Annually release BMI results of 1st, 4th, 7th and 10th graders in 80 school districts; share data with school nurses. | | | | X |
| 3. Collect mother's pre-pregnancy weight, weight at admission, and mother's height, and associated BMI using the new electronic birth certificate. | | | | X |
| 4. Collect data on pre-pregnancy BMI, physical activity and fruit and vegetable intake in the third trimester of pregnancy, breastfeeding initiation and up to eight weeks through PRAMS; | | | | X |

| | | | | |
|---|--|---|--|---|
| share data with WIC and others. | | | | |
| 5. Generate BMI data among women of reproductive age (18-44 years) using current BRFSS data. | | | | X |
| 6. WIC's Eos system generates data related to breastfeeding rates, child overweight/obesity, child sedentary activity and maternal weight gain. | | | | X |
| 7. Use the Getting to the Heart of the Matter nutrition assessment tools to initiate counseling related to weight gain and other behaviors closely linked to healthy weight at WIC clinics. | | X | | X |
| 8. Launch a WIC breastfeeding social marketing campaign for health care professionals and pregnant women through radio spots, transit advertising, mall posters and outreach materials. | | | | X |
| 9. Through EIPP and MHVI, maintain formal linkages with medical providers and birthing hospitals; provide education to women on healthy weight and nutrition and highlighted benefits for both women and infants. | | X | | |
| 10. In collaboration with BU and CDC, investigate pre-pregnancy BMI and risk of cesarean using a link between PRAMS and PELL. Submit PRAMS and PELL abstracts to national conferences. | | | | X |

b. Current Activities

Research investigating pre-pregnancy BMI and risk of cesarean section was conducted using a linkage between PRAMS and PELL data, and presented at the National MCH Epidemiology conference in December 2011.

Since Fall 2010, Eos data includes screen time assessment for all children and breastfeeding exclusivity. The CDC-endorsed WHO growth charts are being implemented to assess weight status among WIC participants ages 0 -- 24 months. WIC is launching a Fit WIC initiative, based on Head Start's I am Moving, I am Learning curriculum, designed to increase physical activity among WIC preschoolers. A fact sheet featuring standards for monitoring and assessing weight gain in pregnancy, is being distributed to WIC's medical community partners statewide.

Hospitals have begun to collect breastfeeding exclusivity through the electronic birth certificate, and will be able to utilize this to monitor breastfeeding rates in the future. The Nutrition Division is collaborating with BCHAP to use obesity prevention funds to design and deliver training to hospitals on the Baby Friendly Hospital Initiative.

Using the 2007 NSCH data, BFHN Office of Data Translation participated in a CDC-sponsored research course to investigate the association between weight status and mental health indicators among MA children 10-17 years. MDPH has submitted the manuscript for publication.

c. Plan for the Coming Year

See also NPM #11 and 14.

The Nutrition Division has trend data by race/ethnicity, age and WIC clinic site for overweight/obesity for children through USDA's PCxx reporting and through WIC's Eos system. Current data sources for children and adolescents aged 6-17 include the National Survey of Children's Health, the Youth Health Survey, and the Youth Risk Behavior Survey (every other year). For women of reproductive age, BRFSS routinely collects BMI data and PRAMS collects data on pre-pregnancy BMI, physical activity and fruit and vegetable intake in the third trimester of pregnancy, and breastfeeding initiation and up to eight weeks. New questions on mother's pre-pregnancy weight, weight at admission, and mother's height have been added on the MA birth

certificate, which will be useful in calculating maternal BMI.

PNSS and PEDNSS surveillance systems are no longer be supported by CDC starting in 2012. MDPH is currently evaluating its capacity to aggregate and analyze these data through USDA's PCxx data set and MA WIC's Eos system.

The Massachusetts Fit WIC initiative will be implemented across local programs, focusing on promotion of physical activity for WIC participants, will be launched. The supermarket tour pilots will be expanded to include two to three additional local programs. All local WIC agencies will continue to set targets for pregnancy weight gain and for breastfeeding initiation and duration at 3 and 6 months as part of the WIC Performance Management System. Consideration will be given to including childhood obesity rate targets as part of the performance management system. The Nutrition Division will provide data to local programs and leadership to monitor aggregated birth certificate data related to breastfeeding exclusivity at hospital discharge. Evaluation data from the Baby Friendly Hospital Initiative training series will be analyzed and shared.

Research studies using the linkage between WIC and the PELL data system surrounding BMI, physical activity, and nutrition will be developed.

Using results from the NSCH analyses in combination with the BMI screenings in schools, MDPH will work closely with school nutrition and physical activity programs to translate this research into practice. The dissemination plan will target school nurses and superintendents with greater than 40% student overweight/obesity to identify district-level physical activity requirements. MDPH is also reaching out to school nurses and superintendents with less than 20% overweight/obesity to identify promising practices regarding physical activity in the adolescent population.

MDPH will include training in healthy weight and breastfeeding as part of core competency for MHVI. Training curriculum and intervention strategies will be shared with all home visiting programs.

State Performance Measure 7: *The rate (per 10,000) of hospitalizations due to asthma among Black, non-Hispanic and Hispanic children aged 0-4 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|--|-------------|-------------|-------------|-------------|-------------|
| Annual Performance Objective | | | | | 71 |
| Annual Indicator | | 79.1 | 71.0 | 76.3 | 71 |
| Numerator | | 729 | 673 | 706 | |
| Denominator | | 92106 | 94803 | 92497 | |
| Data Source | | MA UHDDS | MA UHDDS | MA UHDDS | MA UHDDS |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 70 | 70 | 69.5 | 69 | 69 |

Notes - 2011

Data Source: 2011 Uniform Hospital Discharge Data System data are not available. We have estimated a similar rate to that for 2009, as the 2010 data are thought to have been elevated due to the H1N1 flu outbreak. See 2010 for the most recent actual data and see the Note for 2010 for data sources and other comments.

As the prevalence of childhood asthma continues to rise and many children in this age group may be hospitalized as a precaution even when receiving good medical care, we are projecting only a small improvement in this new measure. Revising it to address a different or wider age group is still under discussion.

Notes - 2010

Data Source: Massachusetts Uniform Hospital Discharge Data System (UHDDS), Division of Health Care Finance and Policy, 2010, the most recent available. The 2010 denominator is from the most recent population estimates for Massachusetts, as provided by the Bureau of Health Information, Statistics, Research and Evaluation. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere.

We believe that the spike in the rate is probably due to the fact that this was the year of H1N1.

As the prevalence of childhood asthma continues to rise and many children in this age group may be hospitalized as a precaution even when receiving good medical care, we are projecting only a small improvement in this new measure. Revising it to address a different or wider age group is under discussion.

Notes - 2009

Data Source: Massachusetts Uniform Hospital Discharge Data System (UHDDS), Division of Health Care Finance and Policy, 2009. The 2009 denominator is from estimates for Massachusetts, as provided by the Bureau of Health Information, Statistics, Research and Evaluation. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere.

a. Last Year's Accomplishments

Essential School Health Services:

Since 2008, Massachusetts has received the State Honor Roll recognition from the Asthma and Allergy Foundation of America for its comprehensive and preferred statewide public policies supporting children with asthma and related allergic diseases in elementary, middle and high schools. The School Health Services Program (SHS) at MDPH played a central role in creating these policies.

Over the last two years, the SHS and its ESHS grantees have made significant progress in improving asthma control in students. Twenty-one school districts partnered with MDPH to implement a continuous quality improvement project on asthma. This project consisted of identifying students who had asthma that interfered with school attendance or full school participation, communicating key asthma messages to parents via materials and phone calls, and tracking the students' health outcomes. Ensuring every child had an Asthma Action Plan was one of the key messages. Overall this project found an increased number of asthma action plans, a decrease in asthma-related visits to school nurse, increased parental perception of good control, and decreased in absenteeism due to asthma.

Bureau of Environmental Health:

The Massachusetts Department of Public Health, Bureau of Environmental Health (MDPH/BEH) implemented a surveillance system to capture asthma prevalence in the 5-14 year old age group beginning for the 2007-2008 school year. This surveillance system, started in 2002, has helped to document the prevalence of pediatric asthma in Massachusetts. This report was released in July 2010. The next report for the 2008 -- 2009 school year is pending publication. BEH also chairs the Taskforce on Indoor Air Quality in Schools and Child Care Setting, a statewide partnership that focuses on improving the indoor environment. This group met twice in 2011. BEH also began the revision of its State Sanitary Code to include prohibiting exposure in rental housing to asthma triggers. In addition, BEH has co-led an advisory group to develop a Healthy Homes Strategic Plan for the state with funding from the CDC. This plan is due to be released this summer.

Asthma Prevention and Control Program:

The APCP has made significant progress on its goals and objectives this fiscal year. It is implementing the HUD-funded READY study to further its efforts to study innovative interventions to address asthma disparities. In addition, it continues to partner with Massachusetts Medicaid (MassHealth) on a bundled payment pilot project to improve asthma care for high risk children and with managed care Medicaid programs in Massachusetts through a recent CMS Innovation award to the Asthma Regional Council of New England. Additional key accomplishments for children include: collaborating with asthma coalitions to improve indoor air quality in child care settings, schools, and homes, partnering with the Massachusetts Asthma Action Partnership to promote smoke-free housing policies, supporting community health worker home asthma education interventions to reduce asthma disparities in children, training 12 community health workers on asthma and home visiting, partnering with the Asthma Regional Council of New England on a CMS Innovations proposal to support interventions developed by APCP, assessing the asthma training landscape and identifying gaps in training in Massachusetts, developing consensus with providers on the template for an electronic asthma action plan and seeking additional resources for this electronic version, and implementing the strategic five year evaluation plan for the program.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Disseminate free print copies of the Massachusetts Asthma Action Plan for adults and children in 8 different languages. | | | | X |
| 2. Support efforts by asthma coalitions to improve local policies on healthy schools and child care settings, healthy homes, and healthy outdoor air in Boston and Springfield. | | | | X |
| 3. Support evidenced-based in-home community health worker asthma education interventions in Boston and Springfield. | | X | | X |
| 4. Promote asthma best practices for high risk pediatric asthma patients with MassHealth and partner in the development of a pilot bundled payment project. | X | | | X |
| 5. Train community health workers to conduct in-home asthma interventions. | | X | | X |
| 6. Conduct the Asthma Call Back Survey for Children as part of the BRFS. | | | | X |
| 7. Chair and participate in the Taskforce on Indoor Air Quality in Schools and Child Care Settings. | | | | X |
| 8. Support the statewide partnership, MAAP, to assist in the implementation of the State Asthma Plan. | | | | X |
| 9. School Nurses conduct continuous quality improvement projects on asthma in funded school districts. | | | | X |
| 10. Conduct the Pediatric Asthma Surveillance System for the 2011 – 2012 school year. | | | | X |

b. Current Activities

School Health Services and BEH will continue with their asthma activities.

The APCP plans to train an additional 10 community health workers from the MassHealth Bundled Payment Initiative and HUD funded healthy homes interventions. It is also conducting a needs assessment on capacity to expand CHW training across the state and to create a referral system for insurers. In addition, it continues to implement the READY study.

The Healthy Homes Strategic Plan will be released this summer 2012. Unfortunately, due to the elimination of CDC Healthy Homes funding, the state has few resources to implement the plan. In the coming year, MDPH will meet regularly to discuss low cost methods of integrating key healthy homes principles into its on-going activities.

Funded by the CDC, APCP plans to develop and disseminate a guidance document for early education and child care providers on managing asthma. This document will be developed over the summer.

APCP has participated in MDPH effort to develop a state Chronic Disease Plan. This plan will be unveiled in June and includes an objective of increasing the number of multi-unit properties with no smoking policies. APCP will lead work on this objective in the coming year. Other objectives focus on improving the built environment, increasing physical activity in children, increasing fruit and vegetable consumption, improving the quality of health care and preventive services, increasing community linkages and providing more data locally.

c. Plan for the Coming Year

See also NPM #3 and continue ongoing activities.

In 2013, MDPH will continue to conduct the interventions mentioned above. As mentioned earlier, it is focusing on low cost methods of implementing the Strategic Healthy Homes Plan for Massachusetts. BEH will continue to revise the State Sanitary Code through a public hearing process. The code may include strong prohibitions on asthma triggers (such as requiring integrated pest management).

MDPH will also implement the statewide chronic plan in 2013. This plan will cover Obesity, Heart Disease and Stroke, Cancer, Arthritis, Diabetes, Nutrition and Weight Status and Physical Activity and Asthma.

The APCP plans on developing and disseminating the guidance document for early education and child care centers, mentioned above, on how to manage asthma and the environmental factors associated with asthma (pending funding).

In 2013, APCP will update its Asthma Burden Document that summarizes asthma morbidity and mortality for Massachusetts using all 12 data sets available in Massachusetts. It will release this document in the summer or fall of 2013. In addition, if time allows APCP will disseminate local asthma fact sheets that include small area estimates from the BRFSS of adult asthma prevalence, along with other measures currently available for local application.

Through its HUD funding, APCP hopes to intervene with 80 children who have high risk pediatric asthma and their families through an in-home community health worker intervention. It will continue to support the bundled payment pilot program at MassHealth through community health worker training and best practices support and partner with the Asthma Regional Council's CMS Innovation Award project. It will continue to work on sustainable funding for asthma interventions by reaching out to insurers and employers to share best practices and encourage payment reform. It will continue to partner with asthma coalitions and the statewide partnership to implement the State Asthma Plan through improved policies and system change.

APCP also hopes to fund the development of an electronic asthma action plan to be interoperable with medical records, if funding becomes available.

MHVI staff will work with contracted vendors in five high-need communities to link families

receiving evidence-based home visiting to medical homes. In one community (Chelsea), the home visiting program is based in a pediatric clinic that functions as a medical home to their community. How to manage asthma and the environmental factors associated with it will be an integral part of the evidence-based interventions and will be included as a core competency for all home visitors.

State Performance Measure 8: *The rate (per 100,000) of unintentional motor vehicle traffic occupant deaths among youth aged 15-19 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|--|-------------|---------------------|---------------------|---------------------|---------------------|
| Annual Performance Objective | | | | | 9.3 |
| Annual Indicator | | 9.4 | 5.2 | 4.5 | 4.5 |
| Numerator | | 87 | 24 | 21 | |
| Denominator | | 925382 | 463258 | 462756 | |
| Data Source | | Mass. Vital Records | Mass. Vital Records | Mass. Vital Records | Mass. Vital Records |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 4.5 | 4.5 | 4.5 | 4.5 | 4.5 |

Notes - 2011

Data Source: 2011 death data are not available. See 2010 for the most recent data and see the Note for 2010 for data sources and other comments. We have estimated a similar rate to 2010.

Notes - 2010

Data Source: 2010 death data are taken from MDPH Vital Records for the calendar year 2010. The numerator is all MV-traffic deaths to occupants or unspecified persons. The denominator is the 2010 Massachusetts population estimate for the age group for the same year, as provided by the MDPH Bureau of Health Information, Statistics, Research and Evaluation. The resulting denominator and age-specific rates may differ from those previously reported or published elsewhere.

Note that this State Performance Measure is not the same as Health Status Indicator #03C, and it has been modified from our original one proposed in 2008. Unlike H.S.I. #03C, it only measures OCCUPANT deaths, not all motor-vehicle related ones. And we have changed our original age range from 15-24 to 15-19, to focus on adolescent drivers and occupants. Because we cannot change our data for 2008, the trend data look very odd. The correct values for 2008 for the 15-19 age group are 32 deaths and a denominator of 460,398, resulting in a rate/100,000 of 7.0. For interpretation of any trend, the rate for 2007 was 14.2 per 100,000 persons.

We are projecting a level rate through 2016.

Notes - 2009

Data Source: 2009 death data are taken from MDPH Vital Records for the calendar year 2009. The numerator is all MV-traffic deaths to occupants or unspecified persons. The denominator is the 2009 Massachusetts population estimate for the age group for the same year, as provided by the MDPH Bureau of Health Information, Statistics, Research and Evaluation. The resulting

denominator and age-specific rates may differ from those previously reported or published elsewhere.

Note that this new State Performance Measure is not the same as Health Status Indicator #03C, and it has been modified from our original one proposed in 2008. Unlike H.S.I. #03C, it only measures OCCUPANT deaths, not all motor-vehicle related ones. And we have changed our original age range from 15-24 to 15-19, to focus on adolescent drivers and occupants. Because we cannot change our data for 2008, the trend data look very odd. The correct values for 2008 for the 15-19 age group are 32 deaths and a denominator of 460,398, resulting in a rate/100,000 of 7.0. For interpretation of any trend, the rate for 2007 was 14.2 per 100,000 persons.

There was a marked drop in the occupant death rate in 2008 to 7.8 per 100,000 which may have been due to the implementation of a Massachusetts graduated driver law. The law addresses hours of operation for younger drivers, limits non-adult passengers, and substantially raised the penalties for violations. Our earlier projection for 2011 (which cannot be changed at this time) were erroneously based on the total motor vehicle death rate for the larger age group and is thus much higher than we intend. All projections from FY12 forward have been adjusted.

We are projecting a slight reduction and leveling off of the rate from 2012 through 2016.

a. Last Year's Accomplishments

The Division of Violence and Injury Prevention's Injury Prevention and Control Program has long had a focus on the issue of teen driving safety. This focus continued in FY11 as the program began development of its new five year injury prevention strategic plan. Key among these activities were:

- Coordination with MassPINN (Prevent Injuries Now Network) and the Partnership for Passenger Safety on proposed policy issues. In FY10 these partnerships resulted in the passage of new safe driving legislation including a ban on texting while driving for all ages and a ban on cell phone use for drivers age 16-18. With this strong Graduated Driver's License law in hand IPCP staff began rebuilding their relationship with the Registry of Motor Vehicles which has statutory authority to enforce key provisions, including parental education, of this legislation.
- Facilitation of quarterly meetings of the Partnership for Passenger Safety (PPS). In addition to its Child Passenger Safety Working Group, PPS includes a Teen Driver Safety Working Group.
- Participation on local child fatality review teams, which too frequently involve reviews of crashes involving young drivers and passengers.
- In preliminary work on the development of a new five year Injury Prevention Strategic Plan undertaken by the IPCP, Transportation Injury was identified as a priority area of focus. It is anticipated that this will include a continued focus on teen driving safety as the Strategic Plan is further developed.

SBHC clinicians screened young drivers for seat belt use. In addition, using the CRAFFT tool for substance use assessment clinicians screened young people for the risky behavior of riding in a car with someone who has used alcohol or drugs, including the question: "Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs?" A sub-sample of CRAFFT screening tools administered in SBHCs (n = 561) was analyzed in an effort to determine the predictive positive value of individual questions. Among these, there were 96 positive answers (17.1%) given to this question. All students who gave positive answers to it were counseled by the SBHC clinical staff using motivational interviewing skills (including a decisional matrix) and were offered the option of a referral for treatment.

(See also NPM#10 for additional activities)

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. Coordinate with MassPINN and PPS and their advocacy efforts to support implementation of the GDL law with texting and cell bans. | | | | X |
| 2. Coordinate with staff of the RMV to implement the texting and cell phone bans for young drivers. | | | X | X |
| 3. Support clinician screening for seat belt use and other risky behavior. | | X | | X |
| 4. Participate on local and state Child Fatality Review Teams and review of recommendations related to GDL and young drivers. | | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

In FY12, IPCP continued activities related to teen driving safety as part of its overall focus on motor vehicle safety. As the program continued work to develop the new five year Injury Prevention Strategic Plan (as part of the newly awarded Core Violence and Injury Prevention Program grant from the CDC), it has identified implementation of the state's Graduated Driver's License Law (aka Junior Operator Licensing Law) as a priority. Ongoing work in this area has included:

- Leadership of Partnership for Passenger Safety Teen Driving Working Group, including implementation of the texting and cell phone ban legislation.
- Agreement with the Registry of Motor Vehicles to combine the efforts of the Teen Driving Working Group and their Junior Operator Licensing Law implementation Working Group.
- Participation with the Executive Office of Public Safety and Security's Strategic Highway Safety Plan.
- Ongoing conversation with state health officials and state public safety officials regarding the passage of a primary seat belt bill; particularly seeking ways to leverage the identification of traffic safety as a "Winnable Battle" by the CDC.
- Collaboration with other programs within the Division and Department (youth violence prevention, teen pregnancy prevention) that reach this population to include information about passenger safety in their work.

c. Plan for the Coming Year

See also NPM #10, continue ongoing activities.

As part of the implementation of the focus area targeting teen drivers within the new five year Injury Prevention Strategic Plan, the Injury Prevention and Control Program will:

- Continue to coordinate with MassPINN (Prevent Injuries Now Network) and the Partnership for Passenger Safety on passage of a primary seat belt law, likely in conjunction with legislation that will address racial profiling.
- Co-facilitate quarterly meetings of the combined Partnership for Passenger Safety's Teen Driver Working Group and RMV Junior Operator Licensing Law Working Group.
- Work with the RMV to implement strategies that improve the parent education component

of the JOL law, including moving the parent education component to earlier in the process and requiring specific parental acknowledgement of the information provided.

- Work with the Division of Violence and Injury Prevention's Youth Violence Prevention Program and the Bureau's Office of Adolescent Health to identify initiatives that focus on shared risk and protective factors across a range of healthy behaviors that may influence injury and death rates from MV crashes.

State Performance Measure 9: *The percentage of high school students having missed a school day due to feeling unsafe at or on the way to school.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|--|-------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| Annual Performance Objective | | | | | 3.8 |
| Annual Indicator | | 4.7 | 4 | 4 | 4.8 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | Mass. YRBS Bi-annual Survey | Mass. YRBS Bi-annual Survey | Mass. YRBS Bi-annual Survey | Mass. YRBS Bi-annual Survey |
| Is the Data Provisional or Final? | | | | Final | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 4.8 | 4.6 | 4.6 | 4.5 | 4.5 |

Notes - 2011

This measure is based on information from the Massachusetts Youth Risk Behavioral Survey (MYRBS). Because the MYRBS results are reported as population-based estimates based on weighted survey data, only the percent will be reported, without numerators and denominators. The survey is conducted every other year and the 2011 survey results are reported. The percent reporting missing school due to feeling unsafe at or on the way to school increased from the previous survey and we have adjusted our projections accordingly.

Notes - 2010

This measure is based on information from the Massachusetts Youth Risk Behavioral Survey (MYRBS). Because the MYRBS results are reported as population-based estimates based on weighted survey data, only the percent will be reported, without numerators and denominators. Because the survey is conducted every other year, there are no new data for FY10 and the results of the 2009 survey are reported.

Notes - 2009

This measure is based on information from the Massachusetts Youth Risk Behavioral Survey (MYRBS). Because the MYRBS results are reported as population-based estimates based on weighted survey data, only the percent will be reported, without numerators and denominators. The survey is conducted every other year and the 2009 survey results are reported.

a. Last Year's Accomplishments

See also SPM#2, SPM # 5 and Priority Needs #2 and # 4 for additional related activities.

The Division of Violence and Injury Prevention (DVIP) leads a number of activities that support youth in feeling and being safer in their schools and communities. These programs recognize groups at greater risk for a variety of types of violent victimization -- including young Black and Hispanic men (street and community violence), girls and young women (dating and sexual violence and harassment), and students who identify as or are perceived as GLBT (homo/transphobic violence and harassment).

In 2010 the Child and Youth Violence Prevention (CYVP) Unit within the DVIP worked closely with the Department of Elementary and Secondary Education to develop regulations and model program guidance for the implementation of the bullying prevention law in the state. While the legislation includes a particular focus on the response to bullying, DVIP stressed the importance of including prevention recommendations in the regulations and the model program guidance, including a focus on school climate issues. In 2011, the YRBS did indicate a reduction in the number of students reporting the experience of bullying. Despite this apparent success, their continues to be a significant issue for students who, for reasons of bullying or other issues related to lack of perceived safety, miss school because of feeling unsafe.

DVIP and its programs continued a strong focus on the safety of young people, in schools and the community through a number of activities and initiatives including:

- Continued to manage the Safe Spaces for GLBT Youth Program, including 7 community-based programs and one statewide training initiative, which supports GLBT youth and address homophobia and harassment.
- Funded 28 youth violence prevention and 38 youth at risk programs across the state utilizing a youth development model to promote resiliency and increased safety for young people at high risk for violence.
- Provided training on GLBT 101 to all youth violence and youth at risk providers.
- Continued to work with state domestic and sexual violence coalition as well as rape crisis centers to promote healthy sexuality and reduce sexual violence and harassment.
- Continued to distribute Direct from the Field, a Guide to Bullying Prevention.

Although the MYRBS results for 2006 -2007 cannot be displayed in the data table, the percentages were 4.0% for the 2005-2006 survey and 4.7% for the 2007-2008 survey.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|--|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. DVIP funded community-based providers address youth violence prevention, GLBT youth development, and sexual/dating violence prevention. | | X | | |
| 2. Collaborate with DESE to implement regulations and model program guidance addressing bullying prevention and response. | | | | X |
| 3. Address healthy sexuality and sexual violence prevention for school-aged young people within the Massachusetts Plan for Sexual Violence Prevention. | | | | X |
| 4. Continue to support and manage the Safe Spaces for GLBT Youth Program and work with the Massachusetts Commission on GLBT Youth. | | X | | X |
| 5. Distribute bullying prevention materials. | | | | X |
| 6. Participate in development of a multi-secretariat initiative to address and reduce youth violence, the Governor's Safe and | | | | X |

| | | | | |
|------------------------------|--|--|--|--|
| Successful Youth Initiative. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

DVIP continues its focus on violence and harassment that impacts young people, prioritizing a youth development/resiliency approach to its work. As with many of its priorities, this work has been significantly impacted by funding cuts and in FY12 this work was impacted by a staff vacancy of the Director of Child and Youth Violence Prevention for much of the fiscal year. In FY 12, DVIP has:

- Funded youth violence prevention programs, Safe Spaces for GLBT youth programs, and rape crisis centers and the state coalition addressing domestic and sexual violence to address various components of this work.
- Worked with the Department of Elementary and Secondary Education to update the teen dating violence prevention information available on their website.
- Participated with the Executive Office of Health and Human Services and Executive Office of Public Safety to develop a comprehensive strategy to implement the new Governor's priority to reduce youth violence.
- Hired a new staff person to oversee Safe Spaces for GLBT Youth Program and continued to develop an effective and productive relationship with the Massachusetts Commission on GLBT Youth.
- Worked in the city of Springfield to develop a "trauma response team" (this was a collaborative effort between the Suicide Prevention Program and the Child and Youth Violence Prevention Unit) which was tested during a recent spate of shootings in that city.
- Completed a teen dating violence prevention needs assessment and planning process.

c. Plan for the Coming Year

Continue ongoing activities. See also SPM#2, SPM # 5 and Priority Needs #2 and # 4 for additional related activities.

Many of the Division's youth violence prevention activities will continue to align with the Governor's Safe and Successful Youth Initiative. Additional work in the area of bullying prevention and its connections to the array of violence and suicide/self inflicted injury prevention activities addressed by DVIP is also envisioned. In FY13, we expect this work to include the following:

- Continued coordination with the Executive Office of Health and Human Services, Public Safety and Labor and Workforce Development focusing on the 10 selected cities of the Governor's Safe and Successful Youth Initiative as well as coordination of data collection variables and outcome measures.
- Continued support of the Safe for GLBT Youth Program and additional work collaborating with the Massachusetts Commission on GLBT Youth, including a research project focusing on evaluation of services for GLBT Youth of Color should that be funded by the NIH.
- Continued support of the youth violence prevention and youth at risk providers. These programs will be reproccured in FY13; the program will be consolidated for greater coordination and alignment of the funding streams as well as greater clarity for providers regarding funding priorities, data collection and expected outcomes.
- Work with the Department of Elementary and Secondary Education to finalize and post new/revised teen dating violence information on its website.
- Continue to convene the State Sexual and Dating Violence Prevention Team and ongoing implementation of the state's Sexual Violence Prevention Plan.

The Office of Adolescent Health and Youth Development will continue to provide and build upon

the trauma informed care training offered to teen pregnancy prevention providers to support the provision of trauma informed care during teen pregnancy prevention individual or group sessions especially with youth in foster care and will include such principles in the implementation of its Teen Parenting Prevention Initiative.

State Performance Measure 10: *The percentage of adolescents reporting no current use (in past 30 days) of either alcohol or illicit drugs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|--|-------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| Annual Performance Objective | 59 | 66 | 67 | 67 | 70 |
| Annual Indicator | 66 | 66 | 68 | 68 | 68.6 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | MA bi-annual Youth Hlth Survey | MA bi-annual Youth Hlth Survey | MA bi-annual Youth Hlth Survey | MA bi-annual Youth Hlth Survey |
| Is the Data Provisional or Final? | | | | Provisional | Final |
| | 2012 | 2013 | 2014 | 2015 | 2016 |
| Annual Performance Objective | 69 | 71 | 71 | 72 | 72 |

Notes - 2011

This measure is based on information from the Massachusetts Youth Health Survey (MYHS). Because the MYHS results are reported as population-based estimates based on weighted survey data, only the percent will be reported, without numerators and denominators. The survey is conducted every other year and the 2011 survey results are reported. There was a slight improvement from the previous survey but not enough to change our projections.

Illicit drug use asked about includes those in the HP 2010 definition (with the exception that hashish is not asked), plus specific questions about "club drugs," over-the-counter drugs to get high; use without a prescription of steroids, Ritalin or Oxycontin; and drugs from prescriptions that weren't his/her own.

In 2004 on MYHS, over half (59%) of Massachusetts middle and high school students reported no alcohol or drug use. This became the baseline for this continuing state measure.

Notes - 2010

This measure is based on information from the Massachusetts Youth Health Survey (MYHS). Because the MYHS results are reported as population-based estimates based on weighted survey data, only the percent will be reported, without numerators and denominators. Because the survey is conducted every other year, there are no new data for FY10 and the results of the 2009 survey are reported.

Notes - 2009

This measure is based on information from the Massachusetts Youth Health Survey (MYHS). Because the MYHS results are reported as population-based estimates based on weighted survey data, only the percent will be reported, without numerators and denominators. The survey is conducted every other year and the 2009 survey results are reported. The percentage of

adolescents reporting 'no current use' of alcohol or illicit drugs increased from 66% to 68% from 2007 to 2009.

a. Last Year's Accomplishments

Prevention work continues in 46 programs (15 focused on prevention of fatal and non-fatal opioid overdoses, and 31 focused on prevention of underage -- pre-K to youth 18 -- drinking) across MA. Community needs assessments have identified specific local substance abuse issues and prevention strategies have been chosen that directly relate to the identified problem areas. Strategies involve reducing access to alcohol by changing the community environment using policy change, enforcement, collaboration or other effective environmental strategies. Social marketing campaigns conducted through radio spots, print media, distribution of materials in schools and the Talk about Addiction website have reached over three million people in MA. An interactive YouTube campaign, directed at high need populations, adolescent African-American and Latino males, has been developed and released. The six regional Prevention Centers continue to provide training, technical assistance, and on-line education and information, to funded and non-funded programs across the state. Each Prevention Center also hosts a Prevention Library with many different prevention topics.

The Investigation and Enforcement Division of the MA Alcoholic Beverages Control Commission (ABCC) has trained, advised and partnered with several community coalitions, including the Mothers' Against Drunk Driving Youth in Action Program in conducting local compliance checks. Over the past several years, as the Commission has focused on communities with low rates of compliance, the failure rate has consistently declined.

Evidence-based programs have been expanded, and uniform guidelines have been put in place for needs assessment, reporting, outcomes, and evaluation of prevention programs. One example of evidence suggesting that ongoing activities are having an impact is that current alcohol use (% of students -- middle and high school combined) on the MA Youth Health Survey dropped from 34.5% in 2004 to 30.3% in 2007 and to 28.4% in 2009 and to 26.6% in 2011. A community-based, school centered intervention program for youth continues to show positive outcomes for youth their families and the community. Three programs serve 8 to 13 years old who are at high risk for or involved in delinquency, substance abuse, or experiencing family violence, school failure or social and behavioral problems. The programs served 171 youth and families during FY12.

The Office of Youth and Young Adult Services (OYYAS) continues to provide GAIN training, certification, and capacity building support to clinicians statewide and has joined with the other Northeast states to form the Northeast Regional Collaborative (NERC) that coordinates trainings available to any provider in the participating states. In addition, BSAS partnered with Children's Hospital to provide training on screening (CRAFT) and referral to treatment and community based services. Furthermore, OYYAS and a contracted provider are continuing to pilot a psycho-educational and skill building curriculum to address issues of wellness and recovery with young people.

The adolescent continuum of care continues to meet the needs of youth and families by providing outpatient individual and group counseling, inpatient detoxification and stabilization services, and residential treatment. These programs are evidence-based, gender-specific, trauma-informed, and address co-occurring mental health needs. The programs provide SA treatment, including family treatment as well as adolescents' other health needs, such as medical and dental visits. Centralized intake increases the efficiency and effectiveness of the adolescent continuum of care. Over 2,011 children were served.

Three high schools supporting young people who have chosen to commit to a plan of recovery served 137 youth representing over 44 school districts in MA. A fourth recovery high school is just beginning to provide services.

A workgroup of the Children's Mental Health Task Force that includes DPH focused on early ID of substance use, integration of ongoing screening and linkage of evidence-based treatment programs with primary care. The workgroup endorsed the CRAFFT assessment tool, trained trainers, and developed a tool kit for pediatric primary care settings that is just beginning to be distributed.

Table 4b, State Performance Measures Summary Sheet

| Activities | Pyramid Level of Service | | | |
|---|--------------------------|----|-----|----|
| | DHC | ES | PBS | IB |
| 1. BFHN and BCHAP collaborate on a variety of youth programs and initiatives conducted by BSAS to prevent alcohol and illicit drug use and support community-based programs that target known risk and protective factors. | | | | X |
| 2. Support implementation of the state's Substance Abuse Strategic Plan including multiple policy and programmatic initiatives and an epidemiological work group conducting state and local needs/resource assessment and gap analysis. | | | | X |
| 3. Provide screening, assessment and treatment services for male and female pre-adolescents and adolescents, and continue to increase access to services, including specialized services for high risk youth (e.g., out of school, special health needs). | X | X | X | |
| 4. Increase systematic screening and intervention for substance use and other adolescent risk behaviors, through a DPH-wide Youth and Young Adult Work Group. | | | X | |
| 5. Through BSAS, train MCH vendor clinicians (including SBHC) and, through The School Health Institute, train school nurses and other school personnel re substance abuse including (as relevant) prevention, screening, assessment and treatment. | | | | X |
| 6. Enhance collaboration with the Office for Healthy Communities and Tobacco Control Program to develop, maintain, and support BSAS Prevention Programs and the Regional Centers for Healthy Communities (formerly the Prevention Centers). | | X | | X |
| 7. Promote and support increased youth involvement in the planning and implementing of youth-focused health initiatives. | | | | X |
| 8. Support local community coalitions, including BSAS funding for science/evidence-based prevention programs to address environmental & other sources of risk and protective factors (community-specific or statewide). | | | X | X |
| 9. Implement public information campaigns using paid media and social marketing techniques to promote culturally competent primary prevention among youth. | | | | X |
| 10. Conduct substance abuse surveillance through the combined Youth Health Survey and Youth Risk Behavior Survey and collect/analyze service and/or outcome data from BSAS, BFHN and BCHAP youth programs. | | | | X |

b. Current Activities

BSAS continued to support a "Prevention System," including funding for 31 prevention programs with a particular focus on underage drinking, evidence-based strategies to prevent/reduce unintended fatal and non-fatal opioid overdoses, four Recovery High Schools, an early intervention program for elementary and middle school students in two school districts and a

technical assistance/support system available to all prevention programs in the State.

The curriculum, "Parent Time: Supporting Yourself and Your Child," was developed as a psycho-educational support group aid to address the needs of parents whose children were having problems with alcohol and other drug use. Statewide training is being conducted with participants from diverse community settings.

Continued monthly meetings of the Youth Interagency Work Group (YIWG), coordinate and inform system collaboration with representation from the Departments of Public Health, Mental Health, Child and Family Services Youth Services, Elementary and Secondary Education, other youth-serving agencies, and Medicaid MCOs.

BSAS participated in the development of a Fetal Affect Spectrum Disorder Toolkit that has been distributed to every OB/GYN doctor and health center in the state.

BSAS supported the national SAMHSA Underage Drinking Prevention Town Hall meeting campaign by identifying 60 communities that will host Town Hall meetings.

c. Plan for the Coming Year

BSAS will continue to implement 31 prevention programs with a particular focus on underage drinking. A grant from SAMHSA Center for Substance Abuse Prevention, funding 15 communities to implement evidence-based strategies focused on the prevention/reduction of unintended fatal and non-fatal opioid overdoses will end and be replaced by a new collaborative affecting up to 40 municipalities. The Regional Center for Healthy Community System will be replaced by a new centralized technical assistance and support system.

BSAS will develop a prescription drug abuse prevention website focused on parents. An Alcohol Retailer's Toolkit will be finalized and distributed to alcohol retailers across the state. Parent guides focused on Talking to Your Pre-teen About Alcohol, Tobacco and Other Drugs will be translated into Spanish and Haitian Creole and distributed in communities as needed.

BSAS is finalizing the development of a "Parent's Portal" to inform parents, family members and youth about the range of prevention, intervention, treatment and recovery services.

BSAS is expanding the use of social media as a tool to reach larger numbers of residents with a substance abuse prevention message.

The Interagency Workgroup will continue to implement screening and brief intervention efforts within other state agency programs (DCF, DESE, DYS, and probation).

BSAS continues to support two youth stabilization/detoxification units serving 700 admissions a year. Three Recovery High Schools continue to operate with an average of 40 students enrolled per school and over 90% attendance. A fourth Recovery High School will be fully established increasing the availability of this program to more school districts.

BSAS continues education and capacity building efforts with families with "Parent Time: Supporting Yourself and Your Child" a psycho-educational/support group to address the needs of parents whose children were having problems with alcohol and other drug use.

BSAS, working with the Institute for Health and Recovery, implements a psycho-educational and skill building curriculum, including instruction in areas of yoga, meditation, nutrition and a variety of wellness strategies, aimed to support the recovery process.

BSAS will continue to sponsor trainings on evidence-based practices for providers working with

adolescents in substance abuse treatment settings.

BSAS is working with family support groups Learn 2 Cope and MOAR to build capacity for families seeking support through the recovery process.

MHVI provides home visiting for first time teen parents as well as other families with high needs in 17 MA communities. All MHVI staff will be trained in use of the SBIRT to appropriately screen, respond and refer pregnant and parenting teens with unhealthy substance use or drug use.

FRESH Start works with substance exposed newborns and their families, many of whom are adolescents, helping them to reduce or eliminate unhealthy use of alcohol and illicit drugs.

E. Health Status Indicators

Introduction

The Health Status Indicators are all actively used by Massachusetts to track the health of the Commonwealth and to inform public health policy and practice. These indicators are part of a much larger set of indicators that are routinely reviewed and that help shape efforts to reduce health disparities and target programs appropriately. Analyses by race, ethnicity, age, and other characteristics -- at both the state and local levels -- are key components of our approach. A particular emphasis is working with communities at greatest risk to develop their own capacity to use data to create, implement, and monitor strategic plans. These indicators are also among the risk indicators that we use for tracking and early identification and for needs assessments for procuring community-based services. Massachusetts has been a leader in the development of programs based on data analysis. We have dedicated epidemiology resources and provide leadership using surveillance data, expanding data utilization and applying data to public health policy.

These HSIs are closely related to a number of NPMs, SPMs, and Priority Needs. There is additional information in those sections of the narrative:

For HSIs 1A, 1B, 2A, 2B

NPMs # 8, 15, 17, and 18

SPMs # 1, 4, and 6

Priority Needs #1, 5, 6 and 10

For HSIs 3A, 3B, 3C, 4A, 4B, 4C:

NPM # 10

SPMs # 8 and 9

Priority Needs # 2, 4, 7, and 10

For HSIs 5A, 5B:

NPM # 8, 18

SPM # 1 and 10

Priority Needs # 5, 6, 7, and 10

For this narrative, we are focusing our discussion on several of the Health Status Indicators that we make particular use of in our analytic and priority-setting activities: 01A -- 02B (low and very low birthweight, and plurality); 03A -- 04C (injury deaths and morbidity); 06 (population); and 07 (births).

Health Status Indicators 01A -- 02B (low and very low birthweight, and plurality)

Low birthweight and very low birthweight infants (LBW, weighing less than 2,500 grams; VLBW, weighing less than 1,500 grams) are at increased risk of morbidity and mortality compared with

infants of normal weight and are at higher risk of delayed development and poor school achievement later in life. MDPH uses these Health Status Indicators to monitor the prevalence of LBW and VLBW infants and to track progress in relation to the Healthy People 2020 goals of 7.8% LBW births and 1.4% VLBW. The percentages of LBW and VLBW infants in MA in 2010 were 7.8% and 1.3%. The LBW rate is about 33% higher than it was in 1990 (5.8%) but has remained relatively stable since 2005. The 2010 rates match the 2020 target for LBW and are slightly better than the 2020 target for VLBW.

Data on the percentage of births that are LBW and VLBW, among other indicators, are published annually and widely disseminated in the Massachusetts Birth Book. The proportion of LBW / VLBW births in each community is compared with other communities and the overall state percentages. Each year with the release of the Birth Book, MDPH creates Community Packets which provide city/town specific data on the proportion of LBW / VLBW infants among infants who died in the first year of life.

Data on percent of LBW, VLBW, and preterm infants born at each maternal and newborn care facility in MA are also used to monitor adherence to revised perinatal regulations, implemented in 2006, to ensure that infants are born at birth hospitals licensed at a level of care that is appropriate for their anticipated level of need. These HSIs also enable MDPH to monitor disparities in VLBW by race/ethnicity and other socio-demographic factors (e.g., Medicaid vs. non-Medicaid).

With the full implementation of PRAMS (starting with 2007 births) and ongoing linkages in the population-based Pregnancy to Early Life Longitudinal (PELL) Data System we have steady access to information on perinatal risk factors associated with adverse birth outcomes including LBW /VLBW. Findings from such analyses can be used to inform efforts to develop effective, targeted interventions for the prevention of prematurity and LBW, both at the state level and in concert with local areas at particular risk.

The percentage of LBW / VLBW infants among multiple births is much larger than among singletons. Much of the long-term increase in LBW in Massachusetts is due to an increase in multiple births.

In addition to monitoring the overall prevalence of LBW infants, MDPH stratifies LBW / VLBW trends by plurality. This allows an estimation of what proportion of the increase in LBW / VLBW births can be accounted for by the increase in multiple births. In 2010 (the most recent data available), 5.6% of singleton births were LBW, whereas 51.8% of twins and 93.5% of higher order births were LBW. The percentage of births that were multiples has been relatively stable over the last several years. The total percentage of multiple births (twins, triplets or more) was 4.6% in 2010, a slight decrease from 2002 (4.9%). White mothers continue to have the highest percentage of multiple births.

The percentage of VLBW infants among multiple births is much larger than among singletons. In addition to monitoring the overall prevalence of VLBW infants, MDPH stratifies trends in VLBW by plurality. This allows an estimation of what proportion of the increase in VLBW births can be accounted for by the increase in multiple births. In 2010, the percentage of VLBW births generally improved: singleton births remained at 0.9%, while 8.9% of twins and 28.0% of higher order births were VLBW.

Massachusetts is one of only 14 states with mandated private insurance coverage for fertility treatments. As a result, Massachusetts has the highest proportion of ART procedures per population in the U.S., and consequently ranks first in the nation in the proportion of multiple births. MDPH is conducting two studies using linked data from the PELL data system to examine adverse perinatal and child health outcomes associated with ART use. This work is done through the Massachusetts Outcomes Study of Assisted Reproductive Technology (MOSART) collaborative. The purpose of MOSART is to improve scientific and clinical knowledge about the

associations between assisted reproductive technologies and pregnancy outcomes, infant health, and maternal health, with the goal of improving clinical practice, identifying possible epidemiological risks, and assisting with the development of appropriate and effective programs and policies.

MOSART received funding from NIH for both studies during FY11 to study (1) whether ART is related, independent of subfertility status, to short- and long-term adverse health effects during fetal development, the perinatal period, and early childhood to age three, through a clinical and epidemiological population-based approach, and (2) whether ART is related, independent of subfertility status, to short- and long-term adverse health effects for women through a clinical and epidemiological population-based approach. These two studies will be using novel matched data and providing the foundation for a longitudinal study of women treated with ART in the State of Massachusetts. IRB approvals have been obtained from both MDPH and the Boston University School of Public Health and key staff including a MOSART programmer and MOSART project manager have been hired.

To date, the linkage for the child health study is almost complete and the women's health linkage is underway. A unique, key feature of both research projects is the ability to link the clinical treatment data from the Society for Assisted Reproductive Technology Clinical Outcomes Reporting System (SART CORS) to the PELL Data System. SART CORS linked with PELL's multiple data sources in order to designate pregnancies as having been "sub-fertile" but not exposed to ART treatment, has been explored in great depth during this period, and an algorithm for "SUBFERT" identification has been developed and is being tested. Several conference presentations, documenting this phase of the project, have been prepared at this time. A second MOSART programmer, who will be a lead/supervisory programmer, was hired in FY12.

Health Status Indicators 03A -- 04C (death and hospitalization rates due to unintentional injuries among children, youth, and young adults)

The six Health Status Indicators dealing with unintentional injuries to children, adolescents, and young adults are core MCH and public health indicators used on a regular basis for a number of purposes. Massachusetts has been a leader in the development of injury prevention and control programs based on data analysis. We have dedicated epidemiology resources and provide leadership using injury surveillance data, expanding data utilization and applying data to public health policy. Surveillance of unintentional injuries utilizing statewide death and hospital discharge data and dissemination of findings to DPH program staff as well as state and local audiences continues.

Injury Deaths

Unintentional injuries are the leading cause of death among MA children aged 1-14 years of age. From 1990 to 2008 the unintentional injury death rate for children 0 to 14 yrs declined from 6.2 to 1.8 per 100,000 (N=71 and N= 21, respectively). Our ongoing surveillance of these deaths includes examination of data by age subgroups (<1, 1-4, 5-9 and 10-14 years), sex, race/ethnicity, and by injury cause. The causes of unintentional injury deaths among children vary by age subgroup. For five years (2005-2009), suffocation was the leading cause among infants (N=17), drowning the leading cause among children 1-4 and 5-9 years (N=14 and N=6, respectively), and motor vehicle occupant the leading cause among children 10-14 years (N=12). The three leading causes of unintentional injury deaths in 2009 for MA children 0-14 overall were pedestrian (5), motor vehicle occupant/unspecified (4), and fire/flame (3). In 2009, unintentional injury deaths in youth 5-9 and 10-14 years were the lowest number in 5 years, with reductions primarily in occupant deaths, suffocation and drowning.

These Vital Records data are used in conjunction with other population-based data sources containing information on the magnitude, causes and risk factors for nonfatal injuries in MA, providing us with a rich and comprehensive picture of the injury problem within the

Commonwealth. The findings from these surveillance databases assist us in directing our prevention efforts.

Unintentional injury death data for MA children 0-14 years are disseminated in our annual comprehensive state death report, as well as in numerous injury specific reports, presentations, custom data requests from a variety of public and private organizations, and in MassCHIP, the MDPH's publicly accessible query-based system. We have also worked closely with the CDC and 3 other states to develop a standard report template that will be used broadly by the 28 Core Violence and Injury Prevention Program (Core VIPP) states for the annual reporting of fatal and nonfatal injuries among children 0-5 years. The first of these reports is expected to be produced in Massachusetts in fall 2012. The child unintentional injury data have also been shared with and utilized by state agency coalitions (Partnership for Passenger Safety, Massachusetts Prevent Injury Now! Network - MassPINN), MDPH task forces (Safe Sleep), the newly formed Massachusetts Safe Kids Office, and by child fatality review (CFR) teams. These data have also been used in 2011-2012 for strategic planning (e.g. the MDPH's Unintentional Injury State Plan, where child unintentional injuries and transportation injuries were selected by MassPINN as 2 of 4 priority areas of this plan, and the Massachusetts Department of Transportation's Highway Safety Plan). They have also been included in a number of grant applications and are also presented in detail (by specific cause and by county or district of residence) in our state's Child Fatality Review Annual Reports.

Suffocation deaths in infancy, most of which are sleep related, has been an emerging focus area of our injury prevention efforts. The MDPH has recently updated its safe sleep policy to be in line with the American Academy of Pediatrics and has convened a multidisciplinary task force aimed at implementation of this policy in Massachusetts. This implementation will be done through partnerships with hospitals, other public agencies caring for infants, and with the MA WIC office. In addition, we will expand our surveillance of sudden unexpected infant deaths in order to improve our understanding of the true incidence of these deaths in Massachusetts and the risk factors associated with them.

Overall, during the period 2006-2009, there has been a decline in the three year rolling average rate of MV traffic deaths in children 0-14 years in MA from 1.2 per 100,000 in 2006 to 0.5 in 2009. More detailed analyses on this HSI enable us to examine the proportion of motor vehicle-related deaths by person type (occupant, motorcyclist, MV-pedestrian, and MV-bicyclist) and by age group. Our child booster seat law went into effect June 8, 2008 and this HSI is being used to evaluate the impact of this law on MV-occupant injuries among young children. The law requires use of a booster seat for child occupants up to age 8 or 4'9." This law was selected by the MDPH's Injury Prevention Program as a priority child policy focus area and we are working closely with state partners on plans to enhance its implementation in Massachusetts over the next four years. Statewide surveillance data will assist in the evaluation of these efforts.

We continue to use our surveillance data on occupant injuries extensively in our work to promote a primary seat belt law in MA, incorporating the data findings into a fact sheet which has been used widely by policy makers.

In 2009, there were 87 MV traffic deaths among youth and young adults ages 15-24 years, similar to 2008 and down from 129 in 2007. Of the 87 deaths, 80 (92%) were occupant-related deaths (including motorcyclists). Nine (11%) of the 80 were among 16 and 17 year olds, the focus of our Junior Operator Law (JOL). The number of deaths among this age group has dropped from 20 in 2007 to 9 in 2009. The expanded JOL took effect September 2007. In the summer of 2010, the use of cell phones and texting devices by Junior Operators was prohibited. Similar to the booster seat work, the MDPH's Injury Prevention and Control Program has also prioritized the JOL as the focus of its child/youth policy work for the next 4 years and will be working with our partners on enhancing the implementation of that law in Massachusetts. MDPH staff also sit on the MA Registry of Motor Vehicle's (RMV) Junior Operator License Advisory Committee, where state data is shared pertaining to adolescent drivers. Massachusetts has added the indicator, MV occupant

deaths in youth 15-19 as one of our State Performance Measures, based on our 5-Year Needs Assessment and priority-setting analyses.

Injury hospitalizations / non-fatal injuries

In addition to the detailed surveillance of injury deaths to children, adolescents, and young adults, we utilize the statewide hospital and emergency department databases to monitor the magnitude, trends of nonfatal injuries and to describe the demographic groups at greatest risk. The newly developed state trauma database contains information on seat belt use, child safety seat use, and other protective devices used by the injured patients, alcohol and drug involvement, as well as information on injury severity. We are just beginning to examine the quality of this data, which will eventually be incorporated into reports, materials used to inform policy, and used to evaluate policies and programs aimed at reducing injuries.

Data on nonfatal injuries among children ages 14 years and younger is primarily derived from the MA statewide inpatient hospital, observation stay and emergency department databases, which have traditionally had excellent external cause of injury coding (E coding) rates. (E codes provide information on the intent and mechanism of the injury.) In 2011-2012, we examined the quality of the E codes used for surveillance among children hospitalized for injury through medical record abstraction of a sample of cases. We expect that the results will not only help us understand the accuracy of these codes in general, but also the sensitivity and positive predictive value of select childhood injuries (falls from a window/building, and off road vehicle injuries).

Injury-related inpatient hospitalizations among children 0-14 years remained relatively stable in MA from FY2007-2010. Of the 2,521 nonfatal injury-related hospitalizations among this age group in FY2010, information on the mechanism and intent of the injury is available for 97% of the cases. Of these, 90% were unintentional injuries, 3% were assault-related (and 40% of these were in infants less than 1 year), and 3% were self-inflicted. Falls were the leading cause of unintentional injury hospitalizations for all age subgroups in the 0-14 year population, accounting for 40% of all unintentional injury hospitalizations in this age group in FY2010.

Twenty percent of all nonfatal unintentional injury hospitalizations in FY 2010 in 0-14 year olds were associated with a traumatic brain injury. In addition, we know from our Youth Health Survey that 20.8 percent of middle school and 21.3 percent of high school youth who participate in sports report having experienced symptoms of a traumatic brain injury following a blow or strike to their head in sports in the past 12 months. We have done considerable work on implementation of a new youth sports concussion law in MA, through promulgation of MDPH regulations, trainings, and other collaborative initiatives. We are now in the beginning stages of evaluating the compliance of these policies by schools and the health impact on student athletes.

Inpatient hospitalizations associated with nonfatal unintentional MV traffic injuries (all person types) in children 0-14 years declined from 2007 through 2010 (190 in 2007 and 154 in 2010, rate 16.1 vs 13.1 per 100,000, respectively). In 2010, 59 (38%) of these hospitalizations were occupant injuries (including motorcyclists); 72 (47%) were pedestrian injuries occurring in MV traffic. Inpatient hospitalizations associated with nonfatal MV occupant injuries in children 0-14 years have declined from 2007-2010 (84 in 2007 and 59 in 2010).

Inpatient hospitalizations associated with nonfatal MV traffic injuries (all person types) also declined significantly from FY2007 to FY2010 for the 15-19 year age group in Massachusetts (from 492 to 332) and slightly the 20-24 year age group (from 496 to 459). Among inpatient hospitalizations for MV occupant injuries (including motorcyclists) specifically, rates from FY2007 to 2010 have significantly declined among the 15-19 year age group and the 16-17 year age group -- the target of our recent junior operator legislation (from 89.0 to 48.8 per 100,000 in the 15-19 year age group and from 99.0 to 46.7 per 100,000 specifically in the 16-17 year age group). We will continue to monitor the impact of the junior operator law with our surveillance data.

Health Status Indicator 06 (Population Demographics)

Massachusetts publishes estimated tables equivalent to HSIs #06A and 06B annually with Vital Records reports on births and deaths, using the sources as noted above. Data are presented for mutually exclusive categories of race and Hispanic ethnicity (i.e. White non-Hispanic, Black non-Hispanic, Native American non-Hispanic, Asian non-Hispanic, and Hispanic) and also by all age groups and by gender. These estimates are used to calculate state-wide population-based rates, both in those reports and for this application.

The estimated population grew by 3.1% between 2000 and 2010, to a total of 6,547,629, according to the 2010 U.S. Census. The age distribution among the MCH populations was virtually unchanged, although slightly less of the population was under age 5 (5.6% versus 5.9% in 2000), reflecting the continued decline in the number of live births each year. Of the total population, 15.8% are females aged 0-24 years; 16.3% are males aged 0-24 years; and 13.5% are women aged 25-44 years. Racial and ethnic minorities constitute 19.6% of the Massachusetts population (non-Hispanic Blacks 6.6%, Hispanics 9.6%, non-Hispanic Asians 5.3%, and two or more races 2.6%). This is a change of 4% since 2000 with a nearly 2% overall increase in the portion of Hispanics. In 2000, minorities constituted 17% of the population (non-Hispanic Blacks 5.5%, Hispanics 6.8%, Asians 3.8%, and two or more races 0.9%). Massachusetts now ranks fourth in the U.S. in the percent of its population being foreign-born persons.

Health Status Indicator 07 (Births)

MDPH uses HSI#07 to understand the trend in number of births to MA mothers by age and race and to monitor the changing demographics of the birth population. The overall number of live births to MA women has declined by 21% since 1990. The overall number declined again in 2010 (down 3% from 2009), for a cumulative drop of 21% since 1990. Another important indicator is the age distribution of mothers giving birth in MA. Compared with 1990, birth rates have increased among mothers aged 30-34 and 40-44 years, and decreased among all the other age groups. The largest increases in birth rates have been observed among mothers aged 40-44 years, while the largest decreases have been observed among the youngest groups (10-14 and 15-19 years). MDPH also examines mean maternal age at first birth (27.7) by race/ethnicity. Hispanic mothers have the youngest average age at first birth (23.2 years) whereas Asian mothers have the highest (29.3 years). The percentage of MA births to minority women (including all mothers who were not non-Hispanic White) increased from 22% in 1990 to 33% in 2010.

Births to women ages 25-34 years accounted for 57% of all births in 2010. Compared with 2009, the 2010 birth rates decreased among mothers ages 25-29 years (by 2%), and 30-34 years (by 0.1%). The decline among the 25-29 age group was driven by a 2% decline in the birth rate of Whites, a 5% decline in birth rate of Blacks, a 3% decline in birth rate of Hispanics, and a 1% decline in the birth rate of Asians.

The percentage of total births to white non-Hispanic women continues to decline (an overall decrease of 15% between 1990 and 2010), while the percentages to Asian, Hispanic, and black non-Hispanic mothers have risen 122%, 59%, and 2% respectively during that time period. The percentages of births to non-US-born mothers remained the same 2009-10 at 27.4%.

Massachusetts has one of the lowest teen birth rates in the country (17.2 births / 1,000 women ages 15-19 in 2010). Teen birth rates have declined for all race and ethnicity groups compared with 1997 rates, but the rate for Hispanics is still over 5 times higher than that for White teens.

These trends were stable in 2010. The proportion of births to Hispanic mothers increased from 9% in 1990 to 14.5% in 2010 (down slightly from 14.7% in 2009). In 2009, there was substantial ethnic diversity among women giving birth with only 39% of mothers classifying themselves as American. The next largest ethnic groups were European (20%), Puerto Rican (6%), African-

American (4%), Brazilian (3%) and Dominican (3%). MDPH also analyzes birth data by maternal nativity. The percentage of MA births to foreign-born mothers has been growing in recent years. In 1990, one out of seven births was to a foreign-born mother whereas in 2010 more than one in four births was to a foreign-born mother.

F. Other Program Activities

In addition to activities contributing to performance measures, a majority of Bureau programs conduct one-time and/or on-going activities directly focused on meeting one or more of the State's currently defined Priority Needs. A description of Program Activities related to our Current Priority Needs and not otherwise covered by the NPM and SPM narratives is attached to this section of the application; plans for FY11 are included for Priority Needs that will continue as a result of our Five-year Needs Assessment. Also in the attachment is a comprehensive list of MCH-related programs and service numbers for FY09, by CH population categories.

/2012/ The 2012 attachment includes a description of Program Activities related to our new Priority Needs and not otherwise covered by the NPM and SPM narratives and an updated listing of MCH-related programs and service numbers for FY10, by MCH population categories. //2012//

/2013/ The 2013 attachment includes updated descriptions of Program Activities related to our new Priority Needs that are not otherwise covered by the NPM and SPM narratives. It also includes an updated listing of MCH-related programs and service numbers for FY11, by MCH population categories. //2013//

An attachment is included in this section. IVF - Other Program Activities

G. Technical Assistance

Massachusetts is considering asking for technical assistance from the Center for Medical Home Improvement (CMHI), which offers a variety of consultation services and has just been awarded a contract to be the National Center on Transition. They are conveniently based nearby in New Hampshire. We would like assistance and guidance in the identification and implementation of strategies to collaborate with primary care providers, specialty care providers, and schools to integrate health-related transition goals into IEPs for CYSHCN. A related need is to help us identify and implement ways to leverage a number of medical home initiatives that are underway in the Commonwealth to improve transition planning.

Both the further development of medical homes for all children and better transitions for CYSHCN (both from early childhood to school and from adolescence to adulthood) are among our new Priorities, and expert advice will help identify the most effective next steps. CMHI offers a number of consultation options (including QI and Learning Collaborative Efforts, Presentations / Workshops, and Development of Facilitation or Coaching Capacity. We have not yet explored the costs of their services but are intrigued with this unique combination of expertise in both

medical home and transition.

//2012/ This year, Massachusetts is considering asking for technical assistance for two projects. First, we would like to request logistical support services from AdCare, a Massachusetts-based organization, to organize and host a full-day Summit in mid to late Fall of key players/stakeholders in MA involved in medical home initiatives (for both children and adults). There are a number of active, innovative initiatives currently going on in Massachusetts focused on medical home across the lifespan. The goal of the Summit is to generate greater consistency of collective purposes and to more broadly share knowledge and support for all of the initiatives, resulting in achieving a "tipping point" of medical home implementation. Having such an event sponsored (or co-sponsored) by the Department of Public Health and the Title V program will provide visibility for the child and family-focused initiatives with which we are involved. Arrangements would include payment for a nationally-recognized keynote speaker, break-out session facilitation, and written summary, along with basic meeting arrangements for space, refreshments, and materials. We do not have the resources to fully fund and provide the necessary logistical support for a major event such as this. Outside logistical help could also support attendance by interested colleagues from the other New England states.

AdCare is used frequently by the Department of Public Health, through a competitively bid master contract, to provide this type of logistical meeting services in a highly professional, one-stop shopping manner.

Our second request is for technical assistance in the form of analytic work and consultation from The Catalyst Center to help prepare us for the impact of full implementation of the Patient Protection and Affordable Care Act (ACA) in 2014 for children and youth with special health needs in Massachusetts, in the context of the existing Massachusetts Health Care Reform environment. We would like to better understand the interfaces between ACA and current Massachusetts laws and regulations, including virtually universal insurance coverage for all children and numerous mandated insurance benefits, etc. Two particular concern are where the new federal requirements may supersede Massachusetts ones that are more beneficial to families and where are the areas where we and our family partners need to focus our attention for training, outreach, and awareness. We have worked with The Catalyst Center before and envision a two-step process of their investigating the Massachusetts-specific environment and then providing us with written analyses and recommendations for maintaining services for CYSHCN and/or taking best advantage of the new opportunities offered by ACA. //2012//

//2013/ Having not yet taken advantage of two earlier technical assistance ideas (in part due to the continued

CYSHCN Director vacancy), Massachusetts is proposing them again for FY13. First, we are considering asking for technical assistance from the Center for Medical Home Improvement (CMHI), the MCHB National Center on Transition. Substantial consultation from families of children and youth with special health care needs shows that many families/youth do not receive information about transition to adult medical care and health care self management skills from their pediatricians. There appear to be multiple reasons for this, including a dearth of knowledgeable adult providers willing to take on patients with pediatric onset conditions and a lack of consistent policies and skill sets among pediatric primary care providers.

To address these issues, Massachusetts would like to request technical assistance from the National Center on Transition, Got Transition, conveniently based in nearby New Hampshire to identify and implement strategies to support community-based pediatricians in developing policies around youth transition and to expand their skill sets to implement these policies in their practices. In addition, the CYSHCN Program would like information about the Transition Learning Collaborative at Children's Hospital working to pair pediatricians with adult providers thereby increasing capacity in the adult medicine community to provide primary care to young adults with special health care needs. We would like to work with our MA State Chapter of the AAP to more broadly support this model.

Our second request would be for technical assistance in the form of analytic work and consultation from The Catalyst Center to help prepare us for the impact of full implementation of the Patient Protection and Affordable Care Act (ACA) in 2014 for children and youth with special health needs in Massachusetts, in the context of the existing Massachusetts Health Care Reform environment. We would like to better understand the interfaces between ACA and current Massachusetts laws and regulations, including virtually universal insurance coverage for all children and numerous mandated insurance benefits, etc. One particular concern is where the new federal requirements may supersede Massachusetts ones which are more beneficial to families Another concern is identifying the areas where we and our family partners need to focus our attention for training, outreach, and awareness. We have worked with The Catalyst Center before and envision a two-step process of they investigate the Massachusetts-specific environment and then provide us with written analyses and recommendations for maintaining services for CYSHCN and/or taking best advantage of the new opportunities offered by ACA. //2013//

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

| | FY 2011 | | FY 2012 | | FY 2013 | |
|---|-----------|-----------|-----------|----------|-----------|----------|
| | Budgeted | Expended | Budgeted | Expended | Budgeted | Expended |
| 1. Federal Allocation (Line1, Form 2) | 11606516 | 8777006 | 11338388 | | 11257008 | |
| 2. Unobligated Balance (Line2, Form 2) | 643484 | 1934265 | 611612 | | 502992 | |
| 3. State Funds (Line3, Form 2) | 49430150 | 45319956 | 45116366 | | 41993077 | |
| 4. Local MCH Funds (Line4, Form 2) | 0 | 0 | 0 | | 0 | |
| 5. Other Funds (Line5, Form 2) | 0 | 0 | 0 | | 0 | |
| 6. Program Income (Line6, Form 2) | 0 | 0 | 0 | | 0 | |
| 7. Subtotal | 61680150 | 56031227 | 57066366 | | 53753077 | |
| 8. Other Federal Funds (Line10, Form 2) | 145789844 | 125770551 | 137658526 | | 157004436 | |
| 9. Total (Line11, Form 2) | 207469994 | 181801778 | 194724892 | | 210757513 | |

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

| | FY 2011 | | FY 2012 | | FY 2013 | |
|---|----------|----------|----------|----------|----------|----------|
| | Budgeted | Expended | Budgeted | Expended | Budgeted | Expended |
| I. Federal-State MCH Block Grant Partnership | | | | | | |
| a. Pregnant Women | 2068883 | 1752527 | 2012743 | | 1760340 | |
| b. Infants < 1 year old | 897567 | 868361 | 934165 | | 881540 | |

| | | | | | | |
|---|-----------|----------|-----------|--|-----------|--|
| c. Children 1 to 22 years old | 17958433 | 11292118 | 9686821 | | 11957672 | |
| d. Children with Special Healthcare Needs | 32691414 | 37661178 | 38384271 | | 33961846 | |
| e. Others | 6882889 | 3464987 | 4988726 | | 4025094 | |
| f. Administration | 1180964 | 992056 | 1059640 | | 1166585 | |
| g. SUBTOTAL | 61680150 | 56031227 | 57066366 | | 53753077 | |
| II. Other Federal Funds (under the control of the person responsible for administration of the Title V program). | | | | | | |
| a. SPRANS | 951481 | | 871411 | | 334664 | |
| b. SSDI | 100000 | | 100000 | | 100000 | |
| c. CISS | 140000 | | 140000 | | 150000 | |
| d. Abstinence Education | 0 | | 0 | | 0 | |
| e. Healthy Start | 0 | | 0 | | 0 | |
| f. EMSC | 130000 | | 130000 | | 87000 | |
| g. WIC | 130249402 | | 118019456 | | 126687696 | |
| h. AIDS | 964806 | | 879806 | | 500000 | |
| i. CDC | 3796353 | | 3949682 | | 3874435 | |
| j. Education | 7666943 | | 8079076 | | 9573727 | |
| k. Home Visiting | 0 | | 0 | | 10508007 | |
| k. Other | | | | | | |
| ACF | 540859 | | 1050610 | | 1312825 | |
| DOJ | 400000 | | 164047 | | 337000 | |
| HHS/OAH | 0 | | 0 | | 2159082 | |
| SAMHSA | 850000 | | 850000 | | 1380000 | |
| HRSA/ACF_ACA MIECHV | 0 | | 1776000 | | 0 | |
| OAH | 0 | | 1648438 | | 0 | |

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

| | FY 2011 | | FY 2012 | | FY 2013 | |
|---|----------|----------|----------|----------|----------|----------|
| | Budgeted | Expended | Budgeted | Expended | Budgeted | Expended |
| I. Direct Health Care Services | 18682857 | 18088373 | 21946928 | | 20092579 | |
| II. Enabling Services | 19243538 | 18738232 | 13447177 | | 16769771 | |
| III. Population-Based Services | 9639643 | 8768321 | 11388045 | | 6029643 | |
| IV. Infrastructure Building Services | 14114112 | 10436301 | 10284216 | | 10861084 | |
| V. Federal-State Title V Block Grant Partnership Total | 61680150 | 56031227 | 57066366 | | 53753077 | |

A. Expenditures

Expenditures Narrative

See the FY09 /2012/ FY10 //2012// **/2013/ FY11 //2013//**Expended columns in Form 3 (State MCH Funding Profile), Form 4 (Budget Details by Types of Individuals Served), and Form 5 (State Title V Programs Budget and Expenditures by Types of Services). The Form and Field Notes for the Forms provide additional details and explanations about the amounts shown, including differences between budgeted and expended amounts, changes in the levels of funding categories across years, and the sources of state Partnership funds and other Federal funds.

It may appear from Forms 4 and 5 that Massachusetts distributes our funding among MCH Population groups and service types in a variable manner from year to year. This picture is misleading, however, because these Forms present the entire MCH Federal-State Partnership budget, which in our case has been as high as 89% and is now approximately 80% for FY11. We have flexibility in allocating federal Block Grant funds, while the populations to be served by state appropriations are usually closely controlled by the more categorical or earmarked nature of state budget language. A more accurate picture of our commitment to the MCH Populations and Types of Services may be seen in the tables attached to Part V, Section B, which presents data with federal funds and state funds separately over several years. These tables illustrate that the majority of the year to year variation in the relative distribution of funds across population groups is due to variations in state funding. In addition, the target populations for the state funds, as well as the types of services specified by the Legislature, shape the overall percentage distribution of funds across the MCH Pyramid and MCH population groups. /2012/ In FY10, state partnership funds represented 82% of total Partnership expenditures.//2012// **/2013/ In FY11, state partnership funds represented 81% of total Partnership expenditures.//2013//**

The year to year variation within state funds leveled off for several years through FY09, so that the total percentage shares have remained very consistent. This is particularly true for FY10 and FY11, when the dominant pattern has been across-the-board state budget cuts, rather than increases for specific programs areas. However, this pattern remains susceptible to change each year due to changes in the state budget and relative budget priorities at the state level.

Another important factor to note is that increasing amounts of our Partnership state funds are being claimed as match for other federal programs, especially TANF and Medicaid (including FMAP). As we have historically had a very large "over-match" for the MCH Block Grant, and the funds continue to be used for the MCH-related programs, this makes obvious sense for the Commonwealth in order to maximize federal funding. However, as funds are used for these other matching requirements, they are of course removed from the MCH Federal-State Partnership spreadsheets so it does not appear that we are double-counting state match. The result is a gradual reduction in the "over-match" amount and percent -- a trend exacerbated in the last several years by actual outright reductions in state funding. This trend is also increasing interest in using the remaining "over match" for other programs as their historical sources of state match dry up. Because these types of claiming are made against expenditures, the changes will often appear as differences in reported expenditures vs. budgeted amounts, as the final claiming is negotiated and applied after our budgets have been submitted. /2012/ In FY10, a total of \$9,427,273 from state Partnership accounts and programs was used for claiming or match for other federal programs and thus does not appear in the final expenditure totals. These other claiming amounts included the following:

\$612,058 from Family Health Services account used for CHIP H.S.I. match

\$416,448 from Pediatric Palliative Care account used for CMS DSHP match

\$698,444 from Youth Violence Prevention account used for TANF match

\$5,708,245 from School Health Services account used for CHIP H.S.I. match

\$2,617,951 from Teen Pregnancy Prevention account (total) for TANF match

If these funds had been included in Partnership expenditures, state funds would have represented 84% of total expenditures.//2012//

/2013/ In FY11, a total of \$13,389,205 from state Partnership accounts and programs was used for claiming or match for other federal programs and thus does not appear in the final expenditure totals. These other claiming amounts included the following: \$736,459 from Family Health Services account used for CHIP H.S.I. and other federal grant

match

\$25,000 from Early Intervention account -- match for another federal grant

\$661,570 from Pediatric Palliative Care account used for CMS DSHP match

\$163,281 from Youth Violence Prevention account used for TANF match

\$5,304,036 from School Health Services account used for CHIP H.S.I. and other federal grant match

\$2,233,798 from Teen Pregnancy Prevention account (total) for TANF match

\$2,265,061 from Domestic Violence/Sexual Assault Prevention account for CMS DSHP match

If these funds had been included in Partnership expenditures, state funds would have represented 84% of total expenditures.//2013//

B. Budget

The FY11 budget in Forms 2, 3, 4, and 5 reflects the same concerning budget situation at the state level as last year. Federal MCH funds remain steady and we have been able to achieve some cost-savings to stretch them further programmatically.

However, like almost all states, Massachusetts continues to experience a budget crisis of unprecedented proportions, with no real evidence of relief in sight. The FY11 state budget is significantly lower than FY10, which in turn was significantly lower than FY09. So after stabilizing and experiencing some gains over the previous several years, including some new areas of support from the state, the shape and scope of virtually all state programs will be shrinking or changing again in FY11. Some new initiatives will disappear altogether and further cuts during FY11 are very likely.

To add to the difficulties presented by the state budget, health insurance costs for employees are not immune to the general impact of rising health care costs in Massachusetts. This has resulted in increases to the fringe benefit rates charged on federal accounts in each of the last two years; each federal salary dollar now requires just under 50 cents for fringe benefits and indirect costs. Without any substantial increases in our MCH Block Grant funding level, these increases alone are now putting strain on the federal budget again after a few years of relief. These increased costs just to maintain equilibrium are coming at a time when there is enormous pressure and need to fill some critical state funding shortfalls with federal funds until the economy improves.

The Bureau works closely with the MDPH Budget Office and our colleagues in other bureaus to plan for the various contingencies necessary as the state budget is developed, passed, and revised each fiscal year.

The total Partnership budget is made up of \$12,250,000 of MCH Block Grant funds (including carry-forward funds) and \$49,430,150 in state funds (down from an initial \$76,266,360 in FY09.) Massachusetts continues to budget at least 30% of our federal MCH funds for Preventive and Primary Care for Children (30.04%) and for Children with Special Health Care Needs (36.06%). The proportion of federal funds used for Title V Administrative Costs is within the allowable 10% (9.27%). Massachusetts continues to commit funds above our statutory maintenance of effort level from FY1989 of \$23.5M and the state funding still includes Over Match of over \$40M. See the Notes to Form 2 for details.

The \$145,789,844 of Other Federal funds for FY11 comes from over 25 different grants and Interagency Service Agreements with sister agencies. The Bureau continues to have good success in obtaining a wide range of federal categorical grants.

The budget forms do not include substantial amounts of state funding for MCH programs that are used for match for other federal programs (TANF and Medicaid FMAP in particular, along with

other smaller discretionary grants). The programmatic efforts supported by the funds continue to be fully described in our annual reports and plans.

For a more detailed picture of the different distribution of federal and state funds across the MCH Populations and the MCH Pyramid, see the attachment to this Section. Due to its categorical nature, the impact of changes in state funding (now about 80% of the Partnership budget) is not always felt equally across all MCH population groups. Patterns of funding stabilized for several years, but the impact of major budget cuts is causing them to fluctuate again.

/2012/

The FY12 total Partnership budget is made up of \$11,950,000 of MCH Block Grant funds (including carry-forward funds) and \$45,116,366 in state funds (down from an initial \$76,266,360 in FY09.) Massachusetts continues to budget at least 30% of our federal MCH funds for Preventive and Primary Care for Children (30.8%) and for Children with Special Health Care Needs (37.4%). The proportion of federal funds used for Title V Administrative Costs is within the allowable 10% (8.8%). Massachusetts continues to commit funds above our statutory maintenance of effort level from FY1989 of \$23.5M and the state funding still includes Over Match of over \$36M. See the Notes to Form 2 for details.

The \$137,658,526 of Other Federal funds for FY12 comes from 27 different grants and Interagency Service Agreements with sister agencies. The Bureau continues to have good success in obtaining a wide range of federal categorical grants.

The budget forms do not include substantial amounts of state funding for MCH programs that are used for match for other federal programs (TANF, Medicaid DPSH and CHIP H.S.I. in particular). In FY12, we have excluded a total of \$12,563,172 from state Partnership accounts and programs based on estimated claiming or match for other federal programs in FY11. These funds thus do not appear in the Federal-State Partnership total, which is thus artificially low by \$12.5M compared to actual program services and activities. The programmatic efforts supported by the funds continue to be fully described in our annual reports and plans.

These excluded claiming amounts include the following:

\$900,000 from Family Health Services account used for CHIP H.S.I. match

\$744,762 from Pediatric Palliative Care account used for CMS DSHP match

\$700,000 from Youth Violence Prevention account used for TANF match

\$7,840,000 from School Health Services account used for CHIP H.S.I. match

\$2,378,410 from Teen Pregnancy Prevention account (total) for TANF match

If these funds had been included in Partnership expenditures, state funds would have represented 83% of the total partnership budget instead of 79%.

The state budget crunch has eased somewhat, with many accounts being sustained at FY11 levels in the final FY12 state budget which has been signed by the Governor. Of particular importance to the MCH populations is that WIC retained level funding after being cut by about \$3M in earlier versions of the state FY12 budget and the state Early Intervention account was fully funded to meet its expected growth, eliminating what would otherwise have been an unprecedented "bifurcation" of the program to establish different eligibility rules for federal and state funded portions.

Overall, however, public health funding continues to be lower than several years ago and most programs remain under considerable stress. Federal discretionary grant renewals for the coming year are a mixed bag: most CDC grants are being reduced, some up to 10%, while those funded by HRSA or other agencies have been generally level funded to date. However, with the federal FY12 public health budgets still to be finalized, we are concerned about many grants, most critically the MCH Block Grant itself. //2012//

/2013/

The FY13 total Partnership budget is made up of \$11,760,000 of MCH Block Grant funds

(including carry-forward funds) and \$41,993,077 in state funds (down from an initial \$76,266,360 in FY09.) Massachusetts continues to budget at least 30% of our federal MCH funds for Preventive and Primary Care for Children (30.2%) and for Children with Special Health Care Needs (38.1%). The proportion of federal funds used for Title V Administrative Costs is within the allowable 10% (9.85%). Massachusetts continues to commit funds above our statutory maintenance of effort level from FY1989 of \$23.5M and the state funding still includes Over Match of over \$33M. See the Notes to Form 2 for details.

The \$157,004,436 of Other Federal funds for FY13 comes from 27 different grants and Interagency Service Agreements (ISA) with sister agencies. The Bureau continues to have good success in obtaining a wide range of federal categorical grants. New this year is a substantial ISA to provide critical components for the Commonwealth's new Race To The Top Early Learning Challenge grant.

The budget forms do not include substantial amounts of state funding for MCH programs that are used for match for other federal programs (TANF, Medicaid DSHP and CHIP H.S.I. in particular). In FY13, we have excluded an estimated \$12,174,546 from state Partnership accounts and programs based on estimated claiming or match for other federal programs in FY12. These funds thus do not appear in the Federal-State Partnership total, which is thus artificially low by \$12.1M compared to actual program services and activities. The programmatic efforts supported by the funds continue to be fully described in our annual reports and plans.

These excluded claiming amounts include the following:

\$776,459 from Family Health Services account used for CHIP H.S.I. and other federal grant match

\$748,823 from Pediatric Palliative Care account used for CMS DSHP match

\$677,681 from Youth Violence Prevention account used for TANF match

\$5,285,429 from School Health Services account used for CHIP H.S.I. and other federal grant match

\$2,201,272 from Teen Pregnancy Prevention account for TANF match

\$2,484,882 from Domestic Violence & Sexual Assault Prevention account for CMS DSHP match

If these funds had been included in Partnership expenditures, state funds would have represented 82% of the total partnership budget instead of 78%.

For a more detailed picture of the different distribution of federal and state funds across the MCH Populations and the MCH Pyramid, see the updated attachment to this Section.

Overall, however, public health funding continues to be lower than several years ago and most programs remain under considerable stress. Although our state funding looks steady from FY12, totals remain substantially less than in previous years. Federal discretionary grant renewals for the coming year are a mixed bag: most CDC grants are being steadily reduced, while those funded by HRSA or other agencies have been generally level funded to date. However, with the federal FY13 public health budgets still to be finalized, and the threat of sequestration still very real, we are concerned about many grants, most critically the MCH Block Grant itself. //2013//

An attachment is included in this section. VB - Budget

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.